00-034895

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11641

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Gertrude F. Algard	2a. DATE OF DEATH MONTH DAY YEAR	April 12, 1986	2b. HOUR 11:36 AM
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR: April 23, 1903
6. AGE (IN YEARS LAST BIRTHDAY)	82 yrs. YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Delaware	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH	Harford MD.			
10. CITY OR TOWN OF DEATH	Darlington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	4303 Conowingo Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY	---------			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Havre deGrace	YES [X] NO [ ]	1024 Chesapeake Drive 21078

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Harry C. Blest	Elizabeth S. Denny		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	**(IF YES, GIVE WAR OR DATES)**	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT / ADDRESS**
No	-----	221-12-8839	Carroll E. Algard, 1024 Chesapeake Dr. Havre de Grace, Md. 21078

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Renal failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD — 5 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Alzheimer's d.,m.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 19 85, to 4/10 19 86, that (I) (we) last saw the deceased alive on 3/16 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Randall Cronau	MD	[ ] [X] [ ]	4/13/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	**22e. ADDRESS**		
Randall Cronau	721 Wheeler School Rd Whiteford, Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	4/14/86	R.A. Ferris & Co.	West Chester Chester Pa.
24. FUNERAL DIRECTOR NAME / ADDRESS		**25a. DATE REC'D. BY REGISTRAR**	**25b. REGISTRAR'S SIGNATURE**
Lee A. Patterson & Son, Perryville, Md. 21903		APR 14 1986	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-03750

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP_____

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 1642

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	NELLIE	MAY	BECHTOLD

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ — MONTH Apr. DAY 13 YEAR 1986 — 2b. HOUR 10:30 P M

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	IF UNDER 1 YR. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Female	White	Feb. 2, 1904	82 YRS.				

2c. DATE PRONOUNCED DEAD: MONTH April DAY 14 YEAR 1986 — 2d. HOUR 2:30 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Harford County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Havre de Grace	106 Hopkins Road	Homemaker	—

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Harford	Havre de Grace	YES ☐ NO ☒	106 Hopkins Road 21078

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
Charles William Campbell	Ada Ruth Campbell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---	218-14-0681	Clarissa B. Rose, 106 Hopkins Road 21078	Havre de Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) A. S. C. V. D.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Luis E Renjel M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 4-14-86

EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D. ADDRESS 464 Alliance St., Havre de Grace, Md. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	April 18, 1986	Harford Memorial Gardens	Aldino	Harford	Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009	APR 16 1986	

00-04746

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11643

1. DECEASED NAME (TYPE OR PRINT): FIRST MAZIE MIDDLE E. LAST BLEVINS
2a. DATE OF DEATH: MONTH 4 DAY 21 YEAR 86
2b. HOUR: 1120 A.M.
3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH Jan. DAY 7, YEAR 1892
6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.
10. CITY OR TOWN OF DEATH: FALLSTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Jarrettsville
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 4064 Federal Hill Rd. 21084

14. FATHER'S NAME: FIRST Franklin MIDDLE W. LAST Perry
15. MOTHER'S MAIDEN NAME: FIRST Zylpha MIDDLE LAST Perish
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 215-14-5387
17. INFORMANT: Hazel Brinegar ADDRESS: Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): End Stage CHD
DUE TO, OR AS A CONSEQUENCE OF (c): Old D. CVA
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/6/86 19 86 to 4/21 19 86 that (I) (we) last saw the deceased alive on 4/21 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 4/21/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): V. S. Nair
22e. ADDRESS: 212 Bel Air Road Suite 101

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 4/23/1986
23c. NAME OF CEMETERY OR CREMATORY: Jarrettsville Cem.
23d. LOCATION: CITY OR TOWN Jarrettsville, COUNTY Harford, STATE Md.

24. FUNERAL DIRECTOR: NAME M. Gladden Kurtz ADDRESS Jarrettsville, Md.
25a. DATE REC'D. BY REGISTRAR: APR 24 1986
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

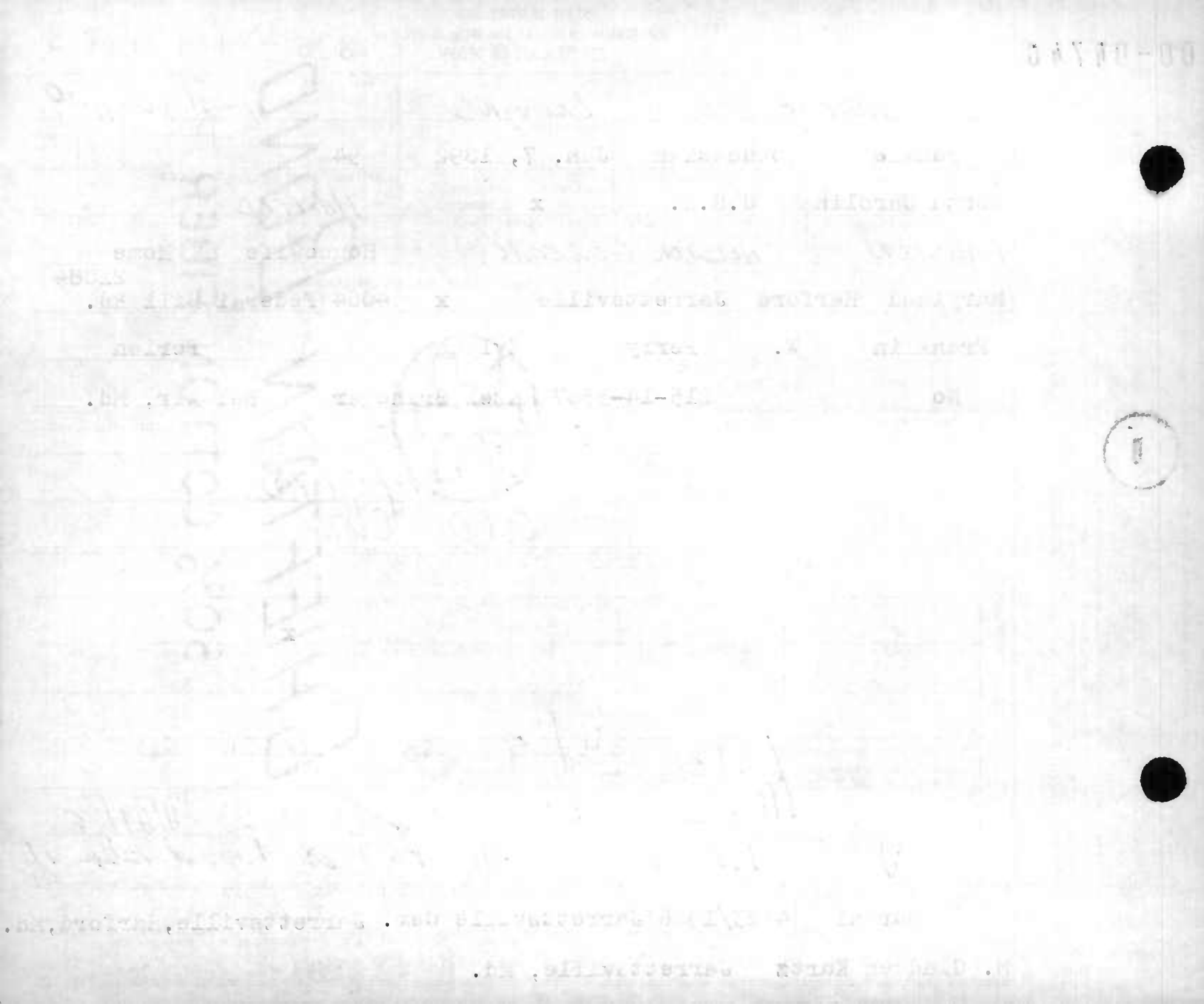
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be registered and the certificate executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)



00-03747

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11644 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
RHODA	E.	BOWMAN	4	15	86	9 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	SEPTEMBER 28, 1902	83 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
VA.	USA		HARFORD MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
HAVRE DE GRACE	CITIZENS NURSING HOME	HOUSE WIFE	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	HARFORD	HAVRE de GRACE	YES ☐ NO ☒	1414 CHAPEL ROAD 21078

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ISSAC		QUESINBERRY	ARLENE		HAWKS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		217 26 7017	MRS. BERNICE BALDWIN 1745 BRYAN ROAD HAVRE de GRACE 21078

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic

DUE TO, OR AS A CONSEQUENCE OF (c) Heart disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/2 19 85, to 4/15 19 86, that (I) (we) last saw the deceased alive on 4/15 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Dante Monakil MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	4/15/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DANTE MONAKIL	Havre de Grace, md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	18APRIL86	BOWMAN FAMILY PLOT	HILLSVILLE, CARROLL CO., VIRGINIA

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MOODY FUNERAL HOME MT. AIRY, N.C. 27030 MITCHELL FUNERAL HOME, PA HAVRE de GRACE, MD. 21078	APR 16 1986	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-04209

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

BP_____

DHMH - 16 60M 7/84
(VRA 1S, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11645

1. DECEASED NAME (TYPE OR PRINT) FIRST: Lewis (LEWIS)	MIDDLE: Edward	LAST: Catron (CATRON)	2a. DATE OF DEATH MONTH: 4 DAY: 17 YEAR: 86	2b. HOUR: 4 57 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 25, 1927	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Smith Co Va.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD	MD.	
10. CITY OR TOWN OF DEATH: FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Assembly Worker	12b. KIND OF BUSINESS OR INDUSTRY: Shoe		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Bel Air	YES ☐ NO ☒	113 Sturgill Drive 21014

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Louis	Robert	Catron	Susia	Victoria	Atwell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	--	226-30-3971	Claude Atwell	12 Central Drive, Port Deposit Md. 21904

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO PULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): OAT CELL CARCINOMA OF LUNG & MAN
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/7/86 to 4/12/86, that (I) (we) last saw the deceased alive on 4/17/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. Edwards — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 4/17/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. EDWARDS — 22e. ADDRESS: 2712 BELAIR RD FALLSTON, MARYLAND 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Apr. 19, 1986	Harford Memorial Gardens	Aldino Harford Md.

24. FUNERAL DIRECTOR NAME: Howard K. McComas III, Abingdon, Md. 21009

25a. DATE REC'D. BY REGISTRAR: APR 21 1986

25b. REGISTRAR'S SIGNATURE: Gina Davidson-Nardone

0-03936

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled state, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11646

1. DECEASED NAME (TYPE OR PRINT) FIRST: James	MIDDLE: Edwin	LAST: Caulford	2a. DATE OF DEATH MONTH DAY YEAR: April 12, 1986	2b. HOUR: 6:25 P.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 12 11 1911	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 1 HR. HOURS MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Supervisor	12b. KIND OF BUSINESS OR INDUSTRY: Civil Service		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Harford	Street	YES [ ] NO [X]	8111 Queenscastle Cr. / 21154

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Walter / / Caulford	Sallie / / Gallion	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		219-10-2080	Elizabeth W. Caulford	3111 Queens Castle Ct. Street Md 21154

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Probable Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hour

DUE TO, OR AS A CONSEQUENCE OF (b): _____

DUE TO, OR AS A CONSEQUENCE OF (c): _____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: COPD, Severe

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/10, 19 86, to 4/12/86, 19____, that (I) (we) last saw the deceased alive on 4/10, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR [X] / STAFF PHYSICIAN	22c. DATE SIGNED
R. de la Rosa	MD		4/12/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
R. delos Santos	517 S. Union Ave. Havre de Grace, Md. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	4/15/86	Fawn Grove Cemetery	Fawn Grove, York Co., PA.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John H. Harkins, 600 Main St., Delta, PA. 17314	APR 16 1986	Julia Davidson-Kendall

00-03150

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11647

1. DECEASED NAME (TYPE OR PRINT) FIRST: GRACE	MIDDLE: CATHERINE	LAST: CULLOM	2a. DATE OF DEATH MONTH DAY YEAR: 04-06-86		2b. HOUR: 12:30a M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 25 1911	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD.		
10. CITY OR TOWN OF DEATH: Darlington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1502 Deerfield Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Darlington	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 1502 Deerfield Road/21034	
14. FATHER'S NAME FIRST: Benjamin	MIDDLE: F.	LAST: Temple	15. MOTHER'S MAIDEN NAME FIRST: Catherine	MIDDLE	LAST: Lee
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 220-03-6231	17. INFORMANT: Alfred E. Cullum	ADDRESS: 1504 Deerfield Road Darlington, MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Severe Left Ventricular Failure

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joseph Reinhardt MD	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): for Dr Vassar	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 4/9/86	23c. NAME OF CEMETERY OR CREMATORY: Ascension Cemetery	23d. LOCATION CITY OR TOWN: Street	COUNTY: Harford STATE: MD
24. FUNERAL DIRECTOR NAME / ADDRESS: John Harkins 600 Main Street Delta, PA 173[illegible]		25a. DATE REC'D BY REGISTRAR: APR 10 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

00-04356

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11648 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before disposition.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Alton	MIDDLE: E.	LAST: Daugherty	2a. DATE OF DEATH MONTH DAY YEAR: April 19 1986	2b. HOUR: 4 05 A M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JUNE 18, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Mem Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) PLUMBER	12b. KIND OF BUSINESS OR INDUSTRY: FED GOVT APG		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: HARFORD	13c. CITY OR TOWN: HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 408 ST. JOHN STREET 21078	
14. FATHER'S NAME FIRST: WILLIAM	MIDDLE: S.	LAST: DAUGHERTY	15. MOTHER'S MAIDEN NAME FIRST: BESSIE	MIDDLE: E.	LAST: DECKMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 217 07 3348	17. INFORMANT ADDRESS: MRS. EDNA E. BUCCHI 419 S. WASHINGTON ST. HdG, MD 21078		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory failure.

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c): COPD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from 3-27, 19 86, to 4-19, 19 86, that (I) (we) last saw the deceased alive on 4-19, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. T. Lee	DEGREE: M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 4/19/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. T. Lee	22e. ADDRESS: Harbor Medical Clinic Havre de Grace		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 22 APRIL 86	23c. NAME OF CEMETERY OR CREMATORY: DUBLIN SOUTHERN CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: DUBLIN, HARFORD CO., MARYLAND	
24. FUNERAL DIRECTOR NAME / ADDRESS: MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR: APR 22 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Hopkins	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

0-02860

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 | 1 1 6 4 9 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: HARMON	MIDDLE: H	LAST: DUVALL	2a. DATE OF DEATH MONTH: 4 DAY: 6 YEAR: 86	2b. HOUR: 955 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 18, 1900	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Howard Co., Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH: FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GEN HOSP	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Road Mtn Worker	12b. KIND OF BUSINESS OR INDUSTRY: State Highway	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Joppa	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 1703 Mountain Road 21085
14. FATHER'S NAME FIRST: Tom	MIDDLE: --	LAST: Duvall	15. MOTHER'S MAIDEN NAME FIRST: Mattie	MIDDLE: -- LAST: Tiplow
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES): --	16b. SOCIAL SECURITY NO.: 213-44-8231	17. INFORMANT: Mrs. Carrie S. Duvall, 1703 Mountain Road	ADD: Joppa, Md. 21085

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Acute Pulmonary Insufficiency, severe
DUE TO, OR AS A CONSEQUENCE OF (c): Hypothermia — probably for cystic chronic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Couple of Days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Severe Anemia s/p Labyrinthectomy Anemia, COPD, ASHD w/ CHF, Cachexia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19: N/S	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 3/31, 19 86, to 4/6, 19 86, that (I) (we) last saw the deceased alive on 4/6, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Manuel M Lazaro — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 4/7/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LAZARO, MANUEL — 22e. ADDRESS: 1131 Belair Rd Bel Air, Md 21014

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: April 9, 1986	23c. NAME OF CEMETERY OR CREMATORY: Mountain Christian Cemetery, Joppa	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Harford Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009	25a. DATE REC'D. BY REGISTRAR: APR 08 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in so far as the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be delivered to the registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

00-03746

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11650

1. DECEASED NAME (TYPE OR PRINT) FIRST: Joseph MIDDLE: WILLIAM LAST: Dye		2a. DATE OF DEATH MONTH DAY YEAR: April 15th 1986	2b. HOUR: M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: AUGUST 8, 1897	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Mem. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) PROC. OFFICER	12b. KIND OF BUSINESS OR INDUSTRY: FED GOVT (PPVAMC)
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: HARFORD	13c. CITY OR TOWN: HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS / ZIP CODE: 701 SOUTH ADAMS STREET 21078			
14. FATHER'S NAME FIRST: JOSEPH MIDDLE: E. LAST: DYE		15. MOTHER'S MAIDEN NAME FIRST: SADIE MIDDLE: E. LAST: SILLS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): WW I	16b. SOCIAL SECURITY NO.: 218 40 7975	17. INFORMANT: MRS. AGNES B. DYE ADDRESS: SAME AS #13e	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): massive aspiration pneumonia (5 days)

DUE TO, OR AS A CONSEQUENCE OF (b): Pseudobulbar palsy & dysphagia (

DUE TO, OR AS A CONSEQUENCE OF (c): (

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4-11, 19 86, to 4-15, 19 86, that (I) (we) last saw the deceased alive on April 14, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Brian T. Yeo DEGREE: MD ATTENDING PHYSICIAN [✓] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] 22c. DATE SIGNED: 4/15/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 18APRIL86	23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: HAVRE de GRACE, HARFORD CO., MD.	
24. FUNERAL DIRECTOR NAME / ADDRESS: MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR: APR 16 1986	25b. REGISTRAR'S SIGNATURE: [signature]	

0-04762

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11651

1. DECEASED NAME (TYPE OR PRINT): FIRST OSCAR MIDDLE JOHN LAST GERMAN, JR.

2a. DATE OF DEATH: MONTH 4 DAY 21 YEAR 86

2b. HOUR: 8:30 P M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: MONTH JAN. DAY 12 YEAR 1914

6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNA.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD.

10. CITY OR TOWN OF DEATH: Fallston

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CUSTODIAN

12b. KIND OF BUSINESS OR INDUSTRY: BALTO. CO. BD. OF ED.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: BALTO.

13c. CITY OR TOWN: PERRY HALL

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 9728 CROSS RD. 21128

14. FATHER'S NAME: FIRST OSCAR MIDDLE GERMAN LAST SR.

15. MOTHER'S MAIDEN NAME: FIRST ABBIE MIDDLE UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES GIVE WAR OR DATES): 1932-1936

16b. SOCIAL SECURITY NO.: 187-07-4226

17. INFORMANT ADDRESS: IRENE GERMAN (WIFE) SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Undifferentiated Carcinoma of Lung with Metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from January 85 to April 21 86, that (I) (we) last saw the deceased alive on 4/21 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William P. Amoss DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 4/21/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): William P. Amoss

22e. ADDRESS: 2303 Belair Rd, Fallston MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 4/24/86

23c. NAME OF CEMETERY OR CREMATORY: HOLLY HILL

23d. LOCATION CITY OR TOWN: BALTIMORE COUNTY: MD. STATE

24. FUNERAL DIRECTOR NAME AND ADDRESS: CHIMUNEK FUNERAL HOME, INC. 9705 Belair Rd., Balto. Md. 21236

25a. DATE REC'D. BY REGISTRAR: APR 25 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

00-04457

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11652

1. DECEASED NAME (TYPE OR PRINT): FIRST Robert MIDDLE J LAST Gilley
2a. DATE OF DEATH: MONTH 4 DAY 21 YEAR 86
2b. HOUR 845A M
3. SEX: MALE
4. RACE: White
5. DATE OF BIRTH: MONTH Aug. DAY 13 YEAR 1929
6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penna.
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: HArford MD.
10. CITY OR TOWN OF DEATH: FALLSTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Clerk
12b. KIND OF BUSINESS OR INDUSTRY: Grocery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.
13b. COUNTY: Harford
13c. CITY OR TOWN: Bel Air
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: 106 Prospect Mill Rd. 21014

14. FATHER'S NAME: FIRST Walter MIDDLE Frank LAST Gilley
15. MOTHER'S MAIDEN NAME: FIRST Rettie MIDDLE Marintha LAST Blevins
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES): --
16b. SOCIAL SECURITY NO.: 171-24-5156
17. INFORMANT ADDRESS: Hunter F. Gilley, 108 Prospect Mill Road, Bel Air, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 40 Am
DUE TO, OR AS A CONSEQUENCE OF (b): Severe electrolyte disturbance with SIADH
DUE TO, OR AS A CONSEQUENCE OF (c): Cardiac arrest at admiss 4/9/86
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Severe lung disease for 30 yrs or more

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital) attended the deceased from April 11, 19 86 to April 21, 19 86, that (I) (we) last saw the deceased alive on April 20, 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Albert S.C. Sun
DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 4/21/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Albert S.C. Sun, M.D.
22e. ADDRESS: 1800 Harford Rd. Fallston, MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: April 23, 1986
23c. NAME OF CEMETERY OR CREMATORY: Welcome Home Baptist Cemetery
23d. LOCATION: CITY OR TOWN Bel Air COUNTY Harford STATE Md.
24. FUNERAL DIRECTOR: NAME AND ADDRESS: Howard R. McComas III, Abingdon, Md. 21009
25a. DATE REC'D. BY REGISTRAR: APR 23 1986
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-03329

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 1653

1. DECEASED NAME (TYPE OR PRINT): FIRST Thomas MIDDLE Perry LAST Griffith

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 4 DAY 7 YEAR 1986 — 2b. HOUR 4:42 M

3. SEX: Male — 4. RACE: Caucasian — 5. DATE OF BIRTH: MONTH July DAY 27 YEAR 1913 — 6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 4 DAY 7 YEAR 1986 — 2d. HOUR 4:42 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD County MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer

12b. KIND OF BUSINESS OR INDUSTRY: Engineering

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Frederick — 13c. CITY OR TOWN: Frederick — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 4909 Ridgecrest Court/ 21701

14. FATHER'S NAME: FIRST Howard MIDDLE LAST Griffith

15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE LAST Perry

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW II & Korea

16b. SOCIAL SECURITY NO.: 577 07 4996

17. INFORMANT ADDRESS: Elizabeth L. Griffith (wife) same as #13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Heart Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD - Hypertension Diabetes

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Luis E Renfel — TITLE (SPECIFY): M.D. Deputy MEDICAL EXAMINER — DATE SIGNED: 4-7-86

EXAMINER'S NAME (TYPE OR PRINT): LUIS E RENFEL M D — ADDRESS: 464 ALLIANCE ST. H. de Grace 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: April 10, 1986 — 23c. NAME OF CEMETERY OR CREMATORY: Monocacy Cemetery — 23d. LOCATION CITY OR TOWN: Beallsville COUNTY STATE: Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS: Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave. Rockville, Maryland

25a. DATE REC'D. BY REGISTRAR: APR 11 1986 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson Pendleton

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

00-05317

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11654 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Robert	Thomas	Gschwind	April 29 1986	5:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	DEc. 28, 1933	52 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
Mt. Vernon, N.Y.	USA		Harford County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Churchville	213 Finney Avenue	Mech. Engineer	US-govt.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Churchville	YES [ ] NO [X]	213 Finney Avenue 21028

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Joseph A. Gschwind	Elizabeth Reilly

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Peacetime	1957-59	067-26-9285	Barbara S. Gschwind, 213 Finney Ave,	Churchville, Md. 21028

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hepatic Coma. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis Ca of colon c Liver Mets — 2 years.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
M.W. Ishak	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	4/20/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
M.W. Ishak	700 Seaman Ave Harford Memorial Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	May 1, 1986	R.A. Ferris & Co.	W. Chester Chester Pa.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009	MAY 1 1986	Julia Davidson-Hanson

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

-03133

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11655

1. DECEASED NAME (TYPE OR PRINT) FIRST: VINCENT	MIDDLE: Ross	LAST: Guercio	2a. DATE OF DEATH MONTH DAY YEAR: April 8, 1986		2b. HOUR: 12:30 A.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 11, 1916	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD.		
10. CITY OR TOWN OF DEATH: Bel Air	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 126 Hickory Avenue - Apt. 7		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Consultant		12b. KIND OF BUSINESS OR INDUSTRY: Tax

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford Co.	Bel Air	YES ☒ NO ☐	126 Hickory Avenue - Apt. 7 21014

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Paul — Guercio	Josephine — Zito	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (WIFE) 838-9319	ADDRESS
YES - Army	WW2	213-28-4605	Mrs. Thelma B. Guercio	126 Hickory Avenue - Apt. 7 Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): METASTATIC CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1/21/85	Adenocarcinoma of the esophagogastric junction	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐ ☐	____ 19	____

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 12/12/84, 19____, to present, 19____, that (I) (we) last saw the deceased alive on 2/19/86, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
M.D.,P.A.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	4/8/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Michele T. Cerino, M.D.	Telephone 1-296-9003 7600 Osler Drive, Towson, Maryland 21024

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	April 10, 1986	Bel Air Memorial Gardens	Bel Air, Harford Co., Maryland 21014

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph William Foster	50 W. Broadway & Williams St Bel Air, Maryland 21014	APR 10 1986	Julia Davidson-Randall

00-02680

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11656 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ELVA	MIDDLE: GORRELL	LAST: HALL	2a. DATE OF DEATH MONTH: 4	DAY: 3	YEAR: 86	2b. HOUR: 6:45 A M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 1	DAY: 02	YEAR: 01	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD.				
10. CITY OR TOWN OF DEATH: FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: HARFORD	13c. CITY OR TOWN: BEL AIR	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 26 N. HICKORY AVENUE 21014			
14. FATHER'S NAME FIRST: EDWARD	MIDDLE: A.	LAST: GORRELL	15. MOTHER'S MAIDEN NAME FIRST: CARRIE	MIDDLE	LAST: BRINEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO: 212 12 2528	17. INFORMANT: MR. EOWARD N. HALL	ADDRESS: SAME AS #13e			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (c): CORONARY ATHEROSCLEROSIS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LUIS F. SANCHEZ

22e. ADDRESS: 5 DANHURST CT TOWSON MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 5APRIL86	23c. NAME OF CEMETERY OR CREMATORY: OARLINGTON CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: OARLINGTON, HARFORD CO., MARYLAND
24. FUNERAL DIRECTOR NAME / ADDRESS: MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR: APR 04 1986	25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before disposition of body.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-03179

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11651

1. DECEASED NAME (TYPE OR PRINT)	FIRST Jerry	MIDDLE V.	LAST HAMM	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐	MONTH 4 DAY 3 YEAR 1986
2b. HOUR	6a M				
3. SEX	M	4. RACE	W	5. DATE OF BIRTH MONTH 7 DAY 17 YEAR 40	6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.
IF UNDER 1 YR. MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.		2c. DATE PRONOUNCED DEAD MONTH 4 DAY 3 YEAR 1986	2d. HOUR 11a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	N.C	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.
10. CITY OR TOWN OF DEATH	Street	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	1119 Pylesford Rd	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	FARMER
12b. KIND OF BUSINESS OR INDUSTRY	Agriculture				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	HARFORD	Street	YES ☐ NO ☒	as above 21154

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST VANCE	MIDDLE E.	LAST HAMM	FIRST MARGARET	MIDDLE	LAST BLACKBURN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		212-38-2222	Personal papers	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Heart Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Luis E Reniel M.D. TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED 4-3-86

EXAMINER'S NAME (TYPE OR PRINT) LUIS E Reniel ADDRESS 464 Alliance It Hall

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	APR. 7, 1986	BEL AIR MEMORIAL GDNS.	BEL AIR	HARFORD	MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
JOHN H. HARKINS, 600 MAIN ST., DELTA, PA.	APR 10 1986	Julia Davidson-Randall

0-04733

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remaining pages in an envelope and attach to the body to be buried or cremated. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11658

1. DECEASED NAME (TYPE OR PRINT): FIRST Thomas MIDDLE Patrick LAST Hanlon

2a. DATE OF DEATH: MONTH April DAY 20 YEAR 1986

2b. HOUR 9:05 P.M.

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH April DAY 19 YEAR 1895

6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer

12b. KIND OF BUSINESS OR INDUSTRY: Farming

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford

13c. CITY OR TOWN: Baldwin

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: Park Road 21013

14. FATHER'S NAME: FIRST James MIDDLE LAST Hanlon

15. MOTHER'S MAIDEN NAME: FIRST Margaret MIDDLE LAST Dalton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 212-38-0100

17. INFORMANT: W. Harvey Lynch ADDRESS: Stewartstown, Pa.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Generalized ASCVD

DUE TO, OR AS A CONSEQUENCE OF (b) BK amputations, bilateral

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/20 19 86 to 4/20 19 86, that (I) (we) last saw the deceased alive on 4/20 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Lloyd Yun DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 4/21/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Lloyd D. Yun

22e. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 4/23/1986

23c. NAME OF CEMETERY OR CREMATORY: St. Johns Cem.

23d. LOCATION CITY OR TOWN Hydes COUNTY Baltimore, Md. STATE

24 FUNERAL DIRECTOR NAME: M. Gladden Kurtz ADDRESS: Jarrettsville, Md.

25a. DATE REC'D. BY REGISTRAR: APR 24 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

00-05020

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11659

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
JANET	L.	HARDIMAN	4	23	86	11:20 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
FEMALE	WHITE	2	26	48	38 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Harford County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Joppa	832 Ring Factory Rd.	Housewife	Homemaking

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Joppa	YES ☐ NO ☒	832 Ring Factory Rd. Joppa, Md. 21085

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Felix	E.	Baker	Arlyn	M.	Leib

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		215-54-1692	Warren Hardiman 832 Ring Factory Rd. Joppa, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio- Pulmonary Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Metastatic ~~Brain~~ ~~Lung~~ cancer to Brain	6 months
DUE TO, OR AS A CONSEQUENCE OF (c)	B. Lung Cancer	1-2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Strong smoking history

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/ 19 86 to 4/23 19 86, that (I) (we) last saw the deceased alive on 4/19 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
David McClure	MD		4/24/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
David McClure MD	1131 Belair Rd. Fallston, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Cremation	4-24-86	Westview Mem. Park		Baltimore,	Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
E. F. Lassahn F. H.	11750 Belair Rd. Kingsville, Md. 21087	APR 28 1986	Julia Davidson-Rendeiro

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows injury, an other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

00-03493

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11660

1. DECEASED NAME (TYPE OR PRINT): FIRST Marion MIDDLE E LAST Harris

2a. DATE OF DEATH: MONTH April DAY 12 YEAR 1986

2b. HOUR: 8 01 M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH: MONTH Dec. DAY 18 YEAR 1936

6. AGE (IN YEARS LAST BIRTHDAY): 49 yrs. YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Mem. Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: --------

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Cecil

13c. CITY OR TOWN: Perryville

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 32 Collins Drive 21903

14. FATHER'S NAME: FIRST Earl MIDDLE W. LAST LaRue, Sr.

15. MOTHER'S MAIDEN NAME: FIRST Lillian MIDDLE LAST Milburn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 212-50-4915

17. INFORMANT: Clyde J. Harris, Sr., ADDRESS: Perryville, Md. 21903 32 Collins Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF (b): A.S.C.V.D. + Coronary Artery Disease — 7 years.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Multiple Sclerosis

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 4-12, 19 86, to 4-12, 19 86, that (I) (we) last saw the deceased alive on 4-12, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Edward Loomis, DEGREE M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 4/12/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): EDWARD C. Loo, MD

22e. ADDRESS: Havre de Grace, Md. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: April 15, 1986

23c. NAME OF CEMETERY OR CREMATORY: Jones Mem. Cem.

23d. LOCATION: CITY OR TOWN Port Deposit, COUNTY Cecil, STATE Md.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son ADDRESS: Perryville, Md.

25a. DATE REC'D. BY REGISTRAR: APR 14 1986

25b. REGISTRAR'S SIGNATURE: Marion Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

00-04466

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR — REG. NO. 1661

1. DECEASED NAME (TYPE OR PRINT): FIRST BRUCE; MIDDLE L.; LAST HAWKINS

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 4 DAY 20 YEAR 86 — 2b. HOUR

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: 3-31-62 — 6. AGE (IN YEARS LAST BIRTHDAY): 24 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: 4-20-86 — 2d. HOUR: 3:45a

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Havre de Grace — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer/Etc. — 12b. KIND OF BUSINESS OR INDUSTRY: Construction

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Harford — 13c. CITY OR TOWN: Bel Air — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 727 Hickory Ave./21014

14. FATHER'S NAME: FIRST R. MIDDLE Burton LAST Hawkins

15. MOTHER'S MAIDEN NAME: FIRST Charlotte MIDDLE J. LAST Callahan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): N/A — 16b. SOCIAL SECURITY NO.: 213-86-8871

17. INFORMANT: Lynn Ann Hawkins, Same as Above — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
7 8450

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOURS A.M. P.M. 2:40A MONTH 4 DAY 20 YEAR 86

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART (a) OR PART 2): driver of auto crossed over center line, ran off roadside striking fixed object, subj. ejected

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): hgwy.

21f. LOCATION STREET: Rt.22 1/10 E. of Fountain Green CITY OR TOWN: Belair, Md. COUNTY: STATE:

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Margarita A. Korell M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 4-21-86

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. — ADDRESS: 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 4-23-86 — 23c. NAME OF CEMETERY OR CREMATORY: Bel Air Mem. Gdns. — 23d. LOCATION CITY OR TOWN: Bel Air COUNTY: Harford STATE: Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS: Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399 — 25a. DATE REC'D. BY REGISTRAR: APR 23 1986 — 25b. REGISTRAR'S SIGNATURE: Gina Davidson-Kinder

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

0-03751

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11662

1. DECEASED NAME (TYPE OR PRINT): FIRST BILLY (Billy) MIDDLE EUGENE LAST HILL (H.11)

2a. DATE OF DEATH: MONTH 4 DAY 13 YEAR 86 — 2b. HOUR 9:25 P.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH Jan. DAY 6, YEAR 1939

6. AGE (IN YEARS LAST BIRTHDAY): 47 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Princeton, W.Va.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: Fallston

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON Gen Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Installation-Service Manager

12b. KIND OF BUSINESS OR INDUSTRY: Refrig-A.C.Htg

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Harford — 13c. CITY OR TOWN: Abingdon — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS / ZIP CODE: 1004 Vernon Court 21009

14. FATHER'S NAME: FIRST Lundy MIDDLE Clinton LAST Hill

15. MOTHER'S MAIDEN NAME: FIRST Louise MIDDLE Margaret LAST Howell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes — (IF YES, GIVE DATES): 1957-1960 Peacetime

16b. SOCIAL SECURITY NO.: 216-36-7007

17. INFORMANT — ADDRESS: Ann R. Hill, 1004 Vernon Court, Abingdon, Md. 21009

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrhythmia ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO, OR AS A CONSEQUENCE OF (b): Underlying Coronary artery disease Yrs.

DUE TO, OR AS A CONSEQUENCE OF (c): Atherosclerosis Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/3, 19 86, to 4/3, 19 86, that (I) (we) last saw the deceased alive on 4/3, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Barry W Ohl — DEGREE: M.D. — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BARRY W OHL

22e. ADDRESS: 2003 ROCK SPRING RD. Forest Hill Md. 21050

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: April 16, 1986

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens, Bel Air

23d. LOCATION: CITY OR TOWN — COUNTY: Harford — STATE: Md.

24. FUNERAL DIRECTOR: NAME, ADDRESS: Howard K. McComas III, Abingdon, Md. 21009

25a. DATE REC'D. BY REGISTRAR: APR 16 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner must be notified of the death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

03615
00-03615

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11663

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARTHA	MIDDLE: VIRGINIA	LAST: HOPKINS	2a. DATE OF DEATH MONTH DAY YEAR: APRIL 11, 1986	2b. HOUR: P M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: FEBRUARY 14, 1899	6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH: HAVRE de GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 100 REVOLUTION STREET #407		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET)PROPERTY OFFICER	12b. KIND OF BUSINESS OR INDUSTRY: FED GOVT (APG)

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	HARFORD	HAVRE de GRACE	YES ☒ NO ☐	100 REVOLUTION ST. #407 21078

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
HARRY	G.	HOPKINS	ORSENA	BESTER	HINKSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		218 22 0741	HARRY G. HOPKINS 833 PRIESTFORD RD. OARLINGTON, MD. 21034

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ARRHYTHMIA

DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

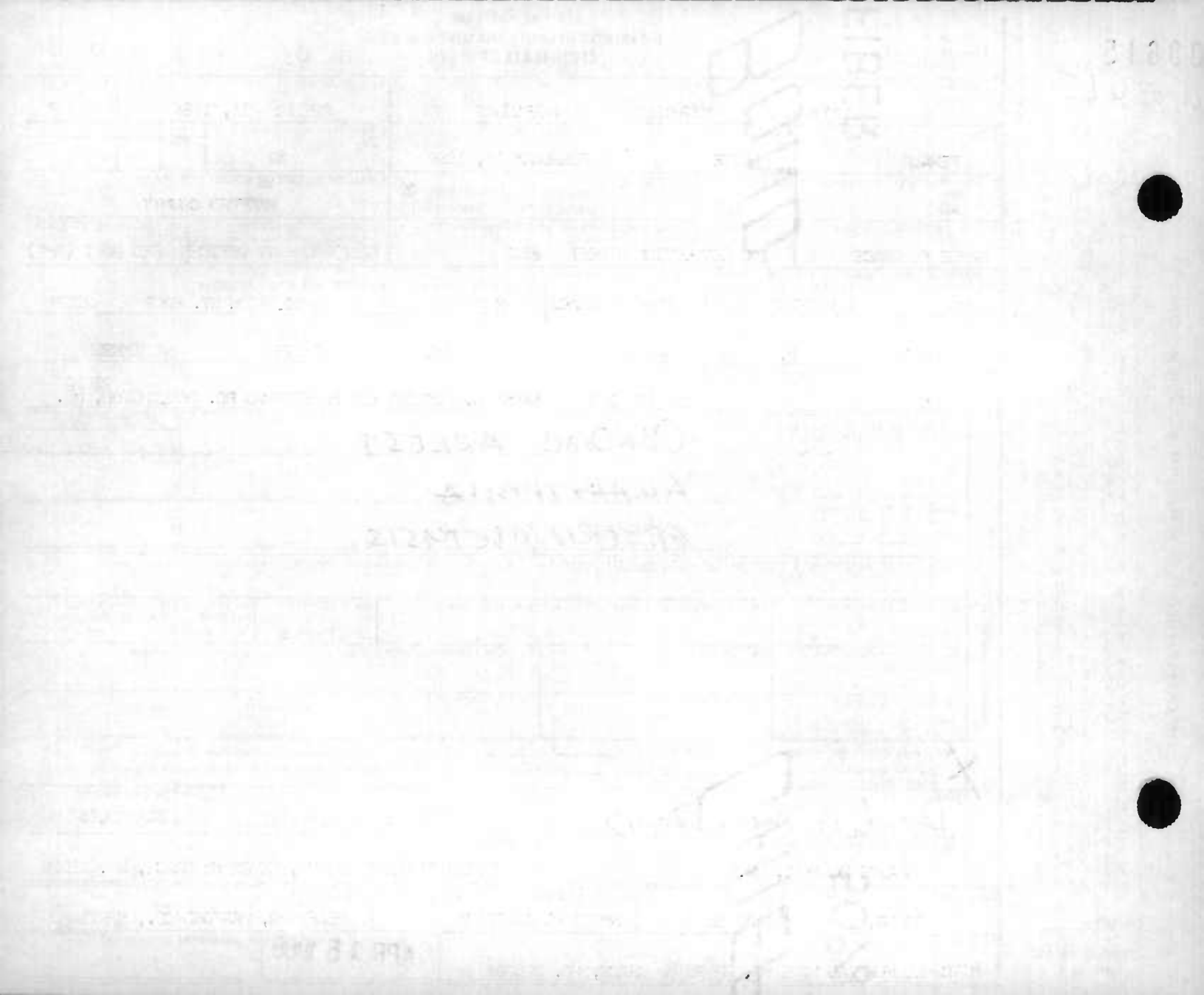
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Dante M. Monakil	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	14APRIL86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
OANTE MONAKIL, MD.	622 SOUTH UNION AVENUE, HAVRE de GRACE, MO. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	14APRIL86	SPESUTIA CEMETERY	PERRYMAN, HARFORD CO., MARYLAND

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MITCHELL FUNERAL HOME PA	HAVRE de GRACE, MD. 21078	APR 15 1986	



0-04355

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11664 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
LUCY	CECILE	HUFFMAN	April 19, 1986	5:35 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	May 13, 1898	87 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Auburn, N.Y.	USA		Harford County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bel Air	Belair Convalescent Center	Registered Nurse	Nursing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Bel Air	YES ☐ NO ☒	1501 Dundee Court 21014

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Thomas	--	Watters	Margaret	--	Donovan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	--	088-26-5652	Mrs. Nancy Orr, 1501 Dundee Court, BelAir, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypertensive A. S. C. V. D. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Recurrence Strokes — 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/10 19 82 to 4/19 19 86, that (I) (we) last saw the deceased alive on 4/19 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Dudley Phillips	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	4-19-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dudley Phillips, M.D.	Darlington, Md. 21034

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	April 23, 1986	St. Joseph's Cemetery	Fleming, Cayuga, New York

24. FUNERAL DIRECTOR NAME, ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009	APR 22 1986	Julia Davidson-Kendall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or coroner, it should be completed and signed by the funeral director. A permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before disposition.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

00-03745

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11665

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

1. DECEASED NAME (TYPE OR PRINT)	FIRST: George	MIDDLE: W	LAST: Johnson	2a. DATE OF DEATH: MONTH April DAY 11 YEAR 1986	2b. HOUR 11:45 PM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: MONTH 2 DAY 16 YEAR 1911	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.		
10. CITY OR TOWN OF DEATH: Havre DeGrace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): AUTO WORKER	12b. KIND OF BUSINESS OR INDUSTRY: CHRYSLER		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Cecil	Rising Sun	YES [ ] NO [X]	8 Anglum Ln 21911

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST Emmitt MIDDLE LAST Johnson	FIRST Nonia MIDDLE Johnson LAST Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES (IF YES, GIVE WAR OR DATES) WWII	218-05-4684	EVA F. JOHNSON	(SAME AS 13)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF (b) COPD & asthmatic Bronchitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c) Cor pulmonale

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from April 8, 1986, to April 11, 1986, that (I) (we) last saw the deceased alive on 4/11, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Brian T. Yeo M.D.	ATTENDING PHYSICIAN [✓] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	4/11/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	4/14/86	West Nottingham	Colora / Cecil / MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
RT Foard Funeral Home	Rising Sun MD.	APR 16 1986	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-06132

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- FOR STATE REGISTRAR Unknown #86-17

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11666

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: David	MIDDLE	LAST: Jones	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR: 2/10/ 19 86	2b. HOUR: M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 9 6 49	6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 2/13/ 19 86	2d. HOUR: 2:55 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD.	
10. CITY OR TOWN OF DEATH: Aberdeen	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Off Ramp Northbound I-95	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Trashman	12b. KIND OF BUSINESS OR INDUSTRY: Sanatation	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
New York		E.Elmhurst	YES ☒ NO ☐	23-30 100th Street 11369

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
- -	Ruby	Jones

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		N/A	Denise R. Jones	194-29 114th Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot Wound to Head & Neck

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	? P.M. FOUND 2/13/ 19 86	subject shot

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☒	wooded area	Northbound Ramp I-95, Aberdeen, Harford, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2/14/86

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	5/9/86	Silver Mount Cemetery	S.Island, N.Y.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
March Funeral Homes 1101 East North Avenue	MAY 9 1986	[signature]

99999 BP 99999

87/84 25M

DHMH - 17
(VR A15 ME (5))

00-05007

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11667

1. DECEASED NAME (TYPE OR PRINT) FIRST: Marian	MIDDLE: E.	LAST: Jones	2a. DATE OF DEATH MONTH: 4	DAY: 22	YEAR: 1986
2b. HOUR: 6:15 P.M.					
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH: April DAY: 27 YEAR: 1910	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Harford	13c. CITY OR TOWN: DARLINGTON	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 161 DARLINGTON Rd. 21034	
14. FATHER'S NAME FIRST: Ocellous	MIDDLE:	LAST: Berry	15. MOTHER'S MAIDEN NAME FIRST: Josephine	MIDDLE:	LAST: Jones
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 219-76-4913	17. INFORMANT: Henry H. Jackson	ADDRESS: P.O. Box 232 Darlington, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CEREBRAL DEATH — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension and

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from March 3, 1986, to April 22, 1986, that (I) (we) last saw the deceased alive on April 22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dante M. Monarki DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 4/23/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DANTE MONARKI — 22e. ADDRESS: Havre de Grace, Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 4/26/1986	23c. NAME OF CEMETERY OR CREMATORY: Hosana Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Darlington, Harford, Md.
24. FUNERAL DIRECTOR NAME: M. Gladden Kurtz	ADDRESS: Jarrettsville, Md.	25a. DATE REC'D. BY REGISTRAR: APR 29 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-04354

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11668

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
WILLIAM	YAGER	KEANE, SR.	April 19, 1986	11 PM M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	Sept. 16, 1924	61 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	USA		Harford County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Joppa	1406 Brierwood Court	Electrical Engr.	US-Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Joppa	YES [ ] NO [X]	1406 Brierwood Court 21085

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Russell	William	Keane	Ida	--	Powell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	215-16-2932	Mrs. Marion P. Keane, 1406 Brierwood Court	Joppa, Md. 21085

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) General Debilitation

DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [XX]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/85 19____ to 4/20/86 19____, that (I) (we) last saw the deceased alive on 4/18/86 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	4-20-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Robert L. Smith, M.D.	Fallston

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	April 23, 1986	Union Chapel Methodist Cemetery	Joppa / Harford / Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009	APR 22 1986	Julia Davidson-Rondeau

00-052344

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11669

1. DECEASED NAME (TYPE OR PRINT): FIRST Brooke MIDDLE C. LAST Keller

2a. DATE OF DEATH: MONTH April DAY 28 YEAR 1986

2b. HOUR: 9:10 P.M.

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: MONTH NOVEMBER DAY 14, YEAR 1921

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) SALESMAN

12b. KIND OF BUSINESS OR INDUSTRY: AUTOMOTIVE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: CECIL

13c. CITY OR TOWN: PERRYVILLE

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 204 CONCORD APTS. 21903

14. FATHER'S NAME: FIRST CHARLES MIDDLE ADAM LAST KELLER

15. MOTHER'S MAIDEN NAME: FIRST SALLIE MIDDLE LAST BECKER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 166 18 9472

17. INFORMANT: MRS. ESTHER K. KELLER ADDRESS: SAME AS #13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John D. Yun DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 4/29/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John D. Yun

22e. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 3MAY86

23c. NAME OF CEMETERY OR CREMATORY: LAUREL DALE CEMETERY

23d. LOCATION: CITY OR TOWN READING, COUNTY BERKS COUNTY, STATE PA.

24. FUNERAL DIRECTOR NAME: LAMN & WITMAN ADDRESS: WERNERSVILLE, PA 19565
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078

25a. DATE REC'D. BY REGISTRAR: APR 30 1986

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

00-02783

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11670
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ERNEST	D.	KENDRICK	APRIL 4, 1986	7:00P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	NOVEMBER 17, 1917	68 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
ARKANSAS	USA		HARFORD COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
HAVRE de GRACE	2100 CHAPEL ROAD	(RET) DRIVER	AUTOMOTIVE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	HARFORD	HAVRE de GRACE	YES [ ] NO [X]	2100 CHAPEL ROAD 21078

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
CLEVE		KENDRICK	VIOLA		FOWLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		431 16 4380	MRS. HAZEL M. KENDRICK	SAME AS #13e

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinomatosis

DUE TO, OR AS A CONSEQUENCE OF

(c) Ca of colon

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Luis E Renjel	MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	5APRIL86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
LUIS E. RENJEL, M.D.	464 ALLIANCE STREET HAVRE de GRACE, MD. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	8APRIL86	ANGEL HILL CEMETERY	HAVRE DE GRACE, HARFORD CO, MD.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078	APR 07 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

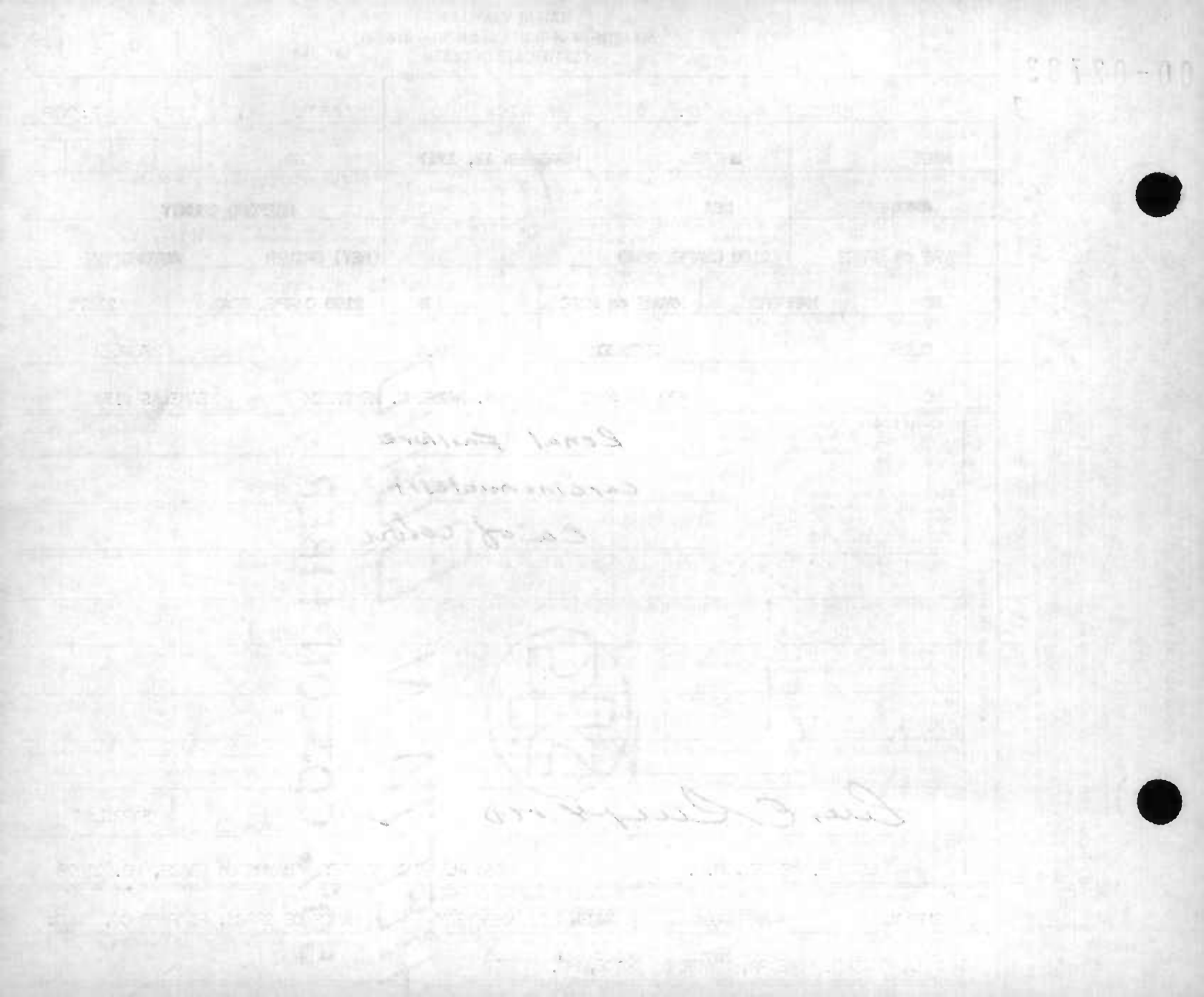
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)



10
00-04250

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11671

1. DECEASED NAME (TYPE OR PRINT) — FIRST: CORNELIA — MIDDLE: — LAST: KIRK

2a. DATE OF DEATH — MONTH: 4 — DAY: 16 — YEAR: 86

2b. HOUR: 1:25 PM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH: 7 — DAY: 10 — YEAR: 03

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD County MD.

10. CITY OR TOWN OF DEATH: FALLSTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSP.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Harford — 13c. CITY OR TOWN: Bel Air — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 308 Linwood Ave. 21014

14. FATHER'S NAME — FIRST: Edward — MIDDLE: C. — LAST: Wilson

15. MOTHER'S MAIDEN NAME — FIRST: Virginia — MIDDLE: — LAST: Jones

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 212-38-2515

17. INFORMANT: Ms. Rosalee Kirk — ADDRESS: 10617 Johns Hopkins Rd. Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO Pulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hour

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ACUTE Myocardial Infarction — hour

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis — YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Subcutaneous Emphysema ? ESOPHAGEAL RUPTURE

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/16, 19 86, to 4/16, 19 86, that (I) (we) last saw the deceased alive on 4/16, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Barry Wolff — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 4/16/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BARRY A. WOLF M.D.

22e. ADDRESS: 2003 ROCKSPRING Rd. FOREST HILL, Md 21050

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 4-16-86

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION — CITY OR TOWN — COUNTY — STATE

24. FUNERAL DIRECTOR — NAME: Anatomy Board — ADDRESS: Balto., Md.

25a. DATE REC'D. BY REGISTRAR: APR 22 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Mandella

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, must be notified above.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-05063

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11672

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Velma	MIDDLE: Palmer	LAST: Krauss	2a. DATE OF DEATH MONTH DAY YEAR: April 23 1986	2b. HOUR: 11:07 P.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 23, 1905	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.	
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Harford	13c. CITY OR TOWN: Aberdeen	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 55 Mount Royal Ave./21001
14. FATHER'S NAME FIRST: Newton	MIDDLE: E.	LAST: Palmer	15. MOTHER'S MAIDEN NAME FIRST: Esther	MIDDLE	LAST: Hall
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 214-16-9442D	17. INFORMANT: Richard P. Krauss, 310 W. Bel Air Ave.,	ADDRESS: Aberdeen, MD, 21001

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for a, b, and c.) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC

DUE TO, OR AS A CONSEQUENCE OF (c): HEART DISEASE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: DIABETES MELLITUS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4-20 19 86, to 4-23 19 86, that (I) (we) last saw the deceased alive on 4-23 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dante M. Monakil — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 4/24/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DANTE MONAKIL — 22e. ADDRESS: Havre de Grace Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 4/27/86	23c. NAME OF CEMETERY OR CREMATORY: Baker Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Aberdeen, Harford, Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399	25a. DATE RECEIVED BY REGISTRAR: APR 29 1986	25b. REGISTRAR'S SIGNATURE:	

00-04745

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11673

1. DECEASED NAME (TYPE OR PRINT) FIRST: Noraetta MIDDLE: Fowler LAST: Kurtz		2a. DATE OF DEATH MONTH DAY YEAR: 4/19/86	2b. HOUR: 11:45 A.M.
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 24, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kentucky	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.
10. CITY OR TOWN OF DEATH: Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher	12b. KIND OF BUSINESS OR INDUSTRY: School

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Darlington	YES ☐ NO ☒	1839 Castleton Rd. 21034

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Hamer Forman Fowler	Anna Elizabeth Dillon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	ADDRESS
No	403-42-8096	Judith Juergensen	same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) General Debilitation

DUE TO, OR AS A CONSEQUENCE OF (c) Widely disseminated adenocarcinoma of breast

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	4/19/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Robert L. Smith	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	4/21/1986	Oak Grove Cem.	Churchville, Harford, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
M. Gladden Kurtz	Jarrettsville, Md.	APR 24 1986	Julia Davidson Bowden

00-04909

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11674

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Helen / N. / Labby	2a. DATE OF DEATH — MONTH DAY YEAR	April 22 1986	2b. HOUR	11:36 A M
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH — MONTH DAY YEAR	9 29 1913
6. AGE (IN YEARS LAST BIRTHDAY)	72 YRS.	IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS. — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Harford County MD.				
10. CITY OR TOWN OF DEATH	Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	L.P.N.
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Baltimore	13c. CITY OR TOWN	
13d. INSIDE CITY LIMITS? YES ☐ NO ☒		13e. STREET ADDRESS / ZIP CODE	7400 Gunpowder Road 21220		
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Henry / / Weitzel	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Anna / / Cook		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	220-09-3130
17. INFORMANT	Lewis B. Labby, Jr.	ADDRESS	Same as 13e		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) CHF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) CRF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 85 to Apr. 22 86 that (I) (we) last saw the deceased alive on Apr. 22 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) LINDA FRAILICH

22e. ADDRESS 1604 Churchville Road

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	4/25/1986	23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
23d. LOCATION — CITY OR TOWN / COUNTY / STATE	Baltimore / Maryland			
24. FUNERAL DIRECTOR NAME / ADDRESS	Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222	25a. DATE REC'D. BY REGISTRAR	APR 28 1986	25b. REGISTRAR'S SIGNATURE

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-024481

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

86 11675 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked yes, then 18 should say injury, or other traumatic event, the medical examiner must be contacted about

1. DECEASED NAME (TYPE OR PRINT) FIRST: FORDMAN	MIDDLE: D	LAST: LARISON	2a. DATE OF DEATH MONTH DAY YEAR: 4-1-86	2b. HOUR: 11 20 AM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: FEBRUARY 19, 1909	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD.		
10. CITY OR TOWN OF DEATH: HAVRE de GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) MUSICIAN	12b. KIND OF BUSINESS OR INDUSTRY: ENTERTAINMENT		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	HARFORD	HAVRE de GRACE	YES [X] NO [ ]	505 CONGRESS AVENUE #507 21078

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
FRED / / LARISON	LETTIE / / ?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW II	218 18 0206A	MRS. GLADYS R. LARISON	SAME AS #13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio respiratory arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral cerebrovascular accident

DUE TO, OR AS A CONSEQUENCE OF (c): Cerebrovascular insufficiency

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Chronic obstructive lung disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
3/25/86	Carcinoma of the colon	YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-3 19 86 to 4/1 19 86 that (I) (we) last saw the deceased alive on 3/31 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (and not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	4/1/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
A. KANAKAWA M.D.	319 Old Union Rd HAVRE DE GRACE MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2APRIL86	ANGEL HILL CEMETERY	HAVRE de GRACE, HARFORD CO., MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078	APR 03 1986	Gloria Davidson-Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

10-06240

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

86 11676 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: LILLIE — MIDDLE: — LAST: LEE

2a. DATE OF DEATH — MONTH: 4 — DAY: 30 — YEAR: 86

2b. HOUR: 10:15am M

3. SEX: Female

4. RACE: Negro

5. DATE OF BIRTH — MONTH: Oct — DAY: 16 — YEAR: 1884

6. AGE (IN YEARS LAST BIRTHDAY): 101 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N. J.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: HAVRE DE GRACE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS OR LOCATION): CITIZENS NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Seamtress

12b. KIND OF BUSINESS OR INDUSTRY: Self Emp

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Harford — 13c. CITY OR TOWN: Darlington — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: Ceder Church Rd. 21034

14. FATHER'S NAME — FIRST: ? — MIDDLE: — LAST: Ongue

15. MOTHER'S MAIDEN NAME — FIRST: Mary — MIDDLE: — LAST: ?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES): —

16b. SOCIAL SECURITY NO.: 263-36-3280

17. INFORMANT — ADDRESS: Marjorie Mimms - Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): old left hip fracture

DUE TO, OR AS A CONSEQUENCE OF (b): CBS

DUE TO, OR AS A CONSEQUENCE OF (c): ABCD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20a. AUTOPSY? YES ☐ NO ☐ — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. T. Lee — DEGREE: M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 5/3/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. T. Lee — 22e. ADDRESS: Union Med. Clinic Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: May 3, 1986 — 23c. NAME OF CEMETERY OR CREMATORY: St. James U.A.M.E. Cem. — 23d. LOCATION: Darlington Harford Md.

24a. FUNERAL DIRECTOR: Otelia J. Bullock — ADDRESS: Havre de Grace Md 21078

25a. DATE REC'D BY REGISTRAR: MAY 13 1986 — 25b. REGISTRAR'S SIGNATURE: Gwendolyn Anderson

IMPORTANT: If item 21 is marked on form, shows any injury, or other traumatic event, the medical examiner must be contacted at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

00-05371

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before any action is taken.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11677

1. DECEASED NAME (TYPE OR PRINT) FIRST: LINDA	MIDDLE: M.	LAST: LEE	2a. DATE OF DEATH MONTH DAY YEAR: 4 30 86	2b. HOUR: 1532 M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 14, 1895	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.		
10. CITY OR TOWN OF DEATH: Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Harford	13c. CITY OR TOWN: Belair	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 401 Old Joppa Rd., 21014	
14. FATHER'S NAME FIRST: (Unknown)	MIDDLE:	LAST: Mollineux	15. MOTHER'S MAIDEN NAME FIRST: (Unknown)	MIDDLE:	LAST:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 219 20 8444	17. INFORMANT: Patricia J. Stang,	ADDRESS: Balto., MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a): Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): laryngeal edema
DUE TO, OR AS A CONSEQUENCE OF (c): intubation secondary to subdural haematoma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive heart failure Pleural effusion pneumonia

19a. DATE OF OPERATION: 3/29/86, 4/1/86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Subdural Haematoma	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21c. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): Patient fell at Harford Mall.	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): Harford Mall	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 3/29, 19 86, to 4/30, 19 86, that (I) (we) last saw the deceased alive on 4/30, 19 86, and that to my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Douglas Abbott	DEGREE: MD	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 4/30/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. Douglas Abbott MD	22e. ADDRESS: 1216 Hartford Road Fallston Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 5/2/86	23c. NAME OF CEMETERY OR CREMATORY: Green Mount	23d. LOCATION CITY OR TOWN: Balto., COUNTY: MD STATE
24. FUNERAL DIRECTOR NAME: Henry W. Jenkins & Sons Co. ADDRESS: 4905 York Road Balto., MD 21212	25a. DATE REC'D. BY REGISTRAR: MAY 2 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Vandeloo	

0-03494

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR — REG. NO. 86 1678

1. DECEASED NAME (TYPE OR PRINT): FIRST Cary; MIDDLE N; LAST Leonard Sr.

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ — MONTH 4 DAY 7 YEAR 19 86 — 2b. HOUR 11:50 M

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH 2 DAY 19 YEAR 19 — 6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 4-7 YEAR 1986 — 2d. HOUR 1:04 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Alabama

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre De Grace

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Restaurant Owner

12b. KIND OF BUSINESS OR INDUSTRY: self Emp.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: Cecil — 13c. CITY OR TOWN: Port Deposit — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 32 Cedar Dr. P.O. Box 14

14. FATHER'S NAME: FIRST John; MIDDLE; LAST Leonard

15. MOTHER'S MAIDEN NAME: FIRST Lillie; MIDDLE; LAST Hudson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 420 14 5591

17. INFORMANT ADDRESS: Helen M. Leonard, Port Deposit, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Heart Disease
Conditions, if any, which gave rise to immediate couse (a) stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 4-7-86

EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D. — ADDRESS 464 Alliance St. HavreDeGrace, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Apr. 10, 1986 — 23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery — 23d. LOCATION CITY OR TOWN: Port Deposit COUNTY: Cecil STATE: Maryland.

24. FUNERAL DIRECTOR (SIGNATURE) — ADDRESS: Lee A. Patterson & Son, Perryville, Maryland. — 25a. DATE REC'D. BY REGISTRAR: APR 14 1986 — 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, AND 2 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

00-03455

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11679

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
NELLIE	R.	LOWE	4	9	1986	6:50 P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
FEMALE	WHITE	JULY 5, 1905	80 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
L.A.	USA	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	HARFORD COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
HAVRE DE GRACE	CITIZENS NURSING HOME	(RET) PRACTICAL NURSE	FED GOVT APG

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	HARFORD	HAVRE de GRACE	YES ☒ NO ☐	505 CONGRESS AVE 21078

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
DAVID	MARTIN	WELCH	LEATHA	JANE	OWENS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		219 16 6072	MRS. JEAN E. ANGELUCCI	605 LEGION DR. HdG, MD 21078

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CEREBRAL DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)	Generalized arteriosclerosis	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/1/86 to 4/9/86, that (I) (we) last saw the deceased alive on 4/9/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Dante Monaki M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	4/10/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DANTE MONAKIL	Havre de Grace Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12APRIL86	HARFORD MEMORIAL GARDENS	ALOINO, HARFORD CO., MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078	APR 14 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or there is any injury, or other traumatic event, the medical examiner must be notified before removal.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1-05395

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11680

1. DECEASED NAME (TYPE OR PRINT): FIRST ROBERT MIDDLE BARGER LAST MAGNESS
2a. DATE OF DEATH: MONTH APRIL DAY 30 YEAR 1986
2b. HOUR: 6 A.M. M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH Oct. DAY 21 YEAR 1913
6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Abingdon, Md.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.
10. CITY OR TOWN OF DEATH: Abingdon
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 312 Amy Drive
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Tax Assessor
12b. KIND OF BUSINESS OR INDUSTRY: State Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Bel Air
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 700 Heritage Lane 21014

14. FATHER'S NAME: FIRST Arthur MIDDLE LAST Magness
15. MOTHER'S MAIDEN NAME: FIRST Katherine MIDDLE LAST Treadwell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES): --
16b. SOCIAL SECURITY NO.: 220-22-0949-A
17. INFORMANT: Virginia C. Magness, ADDRESS: 700 Heritage Lane, Bel Air, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of Lung and
DUE TO, OR AS A CONSEQUENCE OF (c): Hypertensive ASCVD

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senile Dementia (Alzheimers)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/8 19 77 to 4/30 19 86, that (I) (we) last saw the deceased alive on 4/24 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Dudley Phillips DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 4-30-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dudley Phillips, M.D.
22e. ADDRESS: Masonic Bldg., Darlington, Md. 21034

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: May 3,1986
23c. NAME OF CEMETERY OR CREMATORY: St.Francis de Sales Cem.
23d. LOCATION: CITY OR TOWN Abingdon COUNTY Harford STATE Md.
24. FUNERAL DIRECTOR: NAME, ADDRESS: Howard K. McComas III, Abingdon, Md. 21009
25a. DATE REC'D. BY REGISTRAR: MAY 2 1986
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes," the medical examiner must be notified immediately.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

00-03122

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the (chief) director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11681

1. DECEASED NAME (TYPE OR PRINT) FIRST: Louise (2) MIDDLE: MARIE ~~LOUISE~~ LAST: MATASSA		2a. DATE OF DEATH (April 4, 1986) MONTH 4 DAY 4 YEAR 86	2b. HOUR 8:28 M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH January DAY 24 YEAR 1905	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.
10. CITY OR TOWN OF DEATH: Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON Gen. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Auditing office	12b. KIND OF BUSINESS OR INDUSTRY: Department Store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford Co.	Forest Hill	YES ☐ NO ☒	1819 Ridgecroft Drive 21050

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST Pasquale MIDDLE LAST Jerardi	FIRST Catherine MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMAN(Son) 879-7821 ADDRESS
NO	—	219-20-5477	Mr. VINCENT L. MATASSA 1819 Ridgecroft Drive Forest Hill, Maryland 21050

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cerebravascular Hemorrhage, Rt Temporal, Occipital

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-21- 19 86 to 4-4- 19 86 that (I) (we) last saw the deceased alive on 4-4- 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Kermit P. Bonovich	M.D.	☐ ☒ ☐	4-4-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	April 7, 1986	New Cathedral Cemetery	Baltimore, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph William Foster Funeral Home Inc.	50 W. Broadway & Williams St. Bel Air, Maryland 21014	APR 8 1986	Julia Kuykendall

0-05030

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before cremation.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11682

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Bertha E. R. McBride			2a. DATE OF DEATH MONTH DAY YEAR: 4-18-86		2b. HOUR: 1057 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 08-20-02	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Street, Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.		
10. CITY OR TOWN OF DEATH: Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK EOR MOST OF WORKING LIFE): Retired-Seamstress		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Harford	13c. CITY OR TOWN: Cardiff	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: Main Street	21034
14. FATHER'S NAME FIRST / MIDDLE / LAST: SILAS L. ROSS			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: ADA WONDERS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218-28-1897	17. INFORMANT: ELAINE THOMPSON	ADDRESS: WHITEFORD, MD 1730 RIDGE RD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): _____
DUE TO, OR AS A CONSEQUENCE OF (c): _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from APRIL 18, 19 86, to APRIL 18, 19 86, that (I) (we) last saw the deceased alive on N/A 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J Michael Hamilton	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 4/19/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J MICHAEL HAMILTON MD	22e. ADDRESS: FALLSTON GEN HOSP, FALLSTON MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 4-22-86	23c. NAME OF CEMETERY OR CREMATORY: CENTRE CEM.	23d. LOCATION CITY OR TOWN: NEW PARK	COUNTY: YORK STATE: PA
24. FUNERAL DIRECTOR NAME / ADDRESS: JOHN HARKINS 600 MAIN ST. DELTA PA	25a. DATE REC'D. BY REGISTRAR: APR 28 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

00-03469

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11683

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or there is any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST Rebecca MIDDLE Ann LAST McMillan				2a. DATE OF DEATH MONTH DAY YEAR April 12, 1986	2b. HOUR 11:30 A.M.
Rebecca A McMillan					
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 28, 1889	6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sparta, N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dishwasher	12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE 901 Moores Mill Road, BelAir, Md. 21014	
14. FATHER'S NAME FIRST David MIDDLE Martin LAST Moxley			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Jane LAST Halsey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	(IF YES, GIVE WAR OR DATES) —	16b. SOCIAL SECURITY NO. 215-32-8489	17. INFORMANT Mrs. Mary V. Minor	ADDRESS Bel Air, Md. 21014 901 Moores Mill Road	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Decompensation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. — 2 years

DUE TO, OR AS A CONSEQUENCE OF (c) Senility

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Obstructive Jaundice Poss. due to Ca. of the bile duct

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE BLDG., ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (1) (this hospital) attended the deceased from 4-1 19 86 to 4-12 19 86, that (I) (we) last saw the deceased alive on 4/12 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Edward C. Loo, M.D. DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 4/12/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward C. Loo, M.D. — 22e. ADDRESS Havre de Grace, Md. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 16, 1986	23c. NAME OF CEMETERY OR CREMATORY Piney Creek Methodist Cemetery	23d. LOCATION CITY OR TOWN Piney Creek	COUNTY Alleghany STATE N.C.
24. FUNERAL DIRECTOR NAME / ADDRESS Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR APR 14 1986	25b. REGISTRAR'S SIGNATURE Gloria Davidson-Randall	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

0-02862

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11684

1. DECEASED NAME (TYPE OR PRINT): Lillian Marie Myers

2a. DATE OF DEATH: MONTH 4 DAY 3 YEAR 86

2b. HOUR 10 10 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH Aug. DAY 5 YEAR 1902

6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. 13b. COUNTY: Cecil 13c. CITY OR TOWN: Perryville 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE: Broad St. 21903

14. FATHER'S NAME: Charles E. Norman

15. MOTHER'S MAIDEN NAME: Bertha Gallaway

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 215-34-5273

17. INFORMANT: Thomas W. Myers ADDRESS: P.O. Box 57 Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF (b): Emphysema, Pulmonary effusion

DUE TO, OR AS A CONSEQUENCE OF (c): Acute cardiac failure hypocondriac myocardium

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma Breast Met a to Lung Resection

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/25, 19 86, to , 19 , that (I) (we) last saw the deceased alive on , 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John L. Watson DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 4/6/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT):

22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 4-7-86

23c. NAME OF CEMETERY OR CREMATORY: Charlestown Cem.

23d. LOCATION CITY OR TOWN: Charlestown COUNTY: Cecil STATE: Md.

24. FUNERAL DIRECTOR NAME: Grauch Funeral Home ADDRESS: North East, Md.

Robert Glauch

25a. DATE REC'D. BY REGISTRAR: APR 08 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed either 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

0-03043

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with all items completed by the funeral director, page 3, retained by the hospital or attending physician. Page 4 may be detached by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11685

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
DAVID		NIXON	4	1	86	3:50p M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	Black	11	12	98	87 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
North Carolina	USA		HARFORD MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
HAVRE de GRACE	CITIZENS NURSING HOME	Retired	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Harford	Aberdeen	YES ☐ NO ☒	Mitchell Lane 21001

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214-10-9394	Grafton Sconion	1517 Mitchell Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Congestive Heart failure

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

1. Chronic obstructive pulmonary disease 2 Chronic renal

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from September, 19 83, to April, 19 86, that (I) (we) last saw the deceased alive on March 26 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Steve W Kim, MD			4/12/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
SANG W. KIM	308 S. Union Ave. Havre de Grace Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
burial	4-4-86	Mt. Calvary	Aberdeen	Harford	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Arnold Beard	353 Fountain St. Havre de Grace Md.	APR 09 1986	Julia Davidson-Randall

00-05180

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR: Larry Vincent Nowakowski

REG. NO. 86 11686

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Larry	V	Nowakowski	4-26-86		M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
MALE	White	04 03 49	37 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Harford County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
FALLSTON	FALLSTON GENERAL HOSPITAL	Plaster	Construction		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Harford	Edgewood	YES ☐ NO ☐ XX	1934 Eloise Lane 21040

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Frank Nowakowski	Margaret Zemanski

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS
No	216-52-4645	Margaret Nowakowski, Mother 2222 Monocacy Rd Balto Md 21221

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) CHF

DUE TO, OR AS A CONSEQUENCE OF (c) CRF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☑ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 86 to Apr 26 86 that (I) (we) lost sow the deceased alive on Apr 26 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	4/26/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
LINDA FREICHT	604 Church Ln

23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	4/30/86	St. Stanislaus Cemetery	Baltimore Co., Md.

24. FUNERAL DIRECTOR ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bruzdzinski Funeral Home PA 1407 Old Eastern Ave	APR 30 1986	Julia Davidson-Pondexter

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

00-05519

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return cards on pages 1 and 2 which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11687

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN	MIDDLE: EDWARD	LAST: OHLER	2a. DATE OF DEATH MONTH: 4 DAY: 25 YEAR: 86	2b. HOUR: 119 M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: Dec. DAY: 15 YEAR: 1912	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balto. Co. Md.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.		
10. CITY OR TOWN OF DEATH: FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired	12b. KIND OF BUSINESS OR INDUSTRY: Black & Dkr.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Fallston	YES [ ] NO [X]	2305 Harford Rd. 21047

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Francis		Ohler	Mary		Shannahan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		212-10-9628	Mrs. Grace V. Ohler, Fallston, Md.	2305 Harford Rd. 21047

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): I. H. D.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4-25, 19 86, to 4-25, 19 86, that (I) (we) last saw the deceased alive on 4-25, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
J. Reinhardt for Dr. Vassar		[ ] [ ] [ ]	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Joseph Reinhardt For Dr. Vassar	Fallston General Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	4-28-1986	St. John R. C. Ch. Cem.	Long Green, Baltimore Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087	MAY 02 1986	Julia Davidson Randall

00-05494

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 116888

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
George	Allen	Owens	4-27-86	6:00 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	Caucasian	09-18-09	76 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Kentucky	U.S.A.		Harford MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Fallston	Fallston General Hospital	Electrician	U.S. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	HARFORD	PYLESVILLE	YES ☐ NO ☒	100 ST MARYS RD 21132

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
(Unknown)		Owens	unknown		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	220-09-8940	Louise Fletcher	Pylesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Diffuse Interstitial Fibrosis Lung.	
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic Bronchitis - Severe Hypoxaemia	> 4 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)	H/O Asbestos Exposure, Heavy Smoking.	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 4/24 19 86 to 4/27 19 86 that (I) (we) last saw the deceased alive on 4/27 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	22c. DATE SIGNED
B Parekh	MD.				4/28/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
B PAREKH MD.	1908 Harford Rd, Fallstn MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	4/30/1986	Bel Air Mem. Gar.	Bel Air Harford Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
M. Gladden Kurtz	Jarrettsville, Md.	MAY 01 1986	Julia Davidson Registrar

00-04658

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

8 REG NO. 11689

1. DECEASED NAME (TYPE OR PRINT): Lawson Wright Parks Jr.
2a. DATE OF DEATH: 4 16 86
2b. HOUR: 8:00 P M
3. SEX: M
4. RACE: Canc
5. DATE OF BIRTH: Sept. 22, 1902
6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Holland:sIsl.Md.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford Co. MD.
10. CITY OR TOWN OF DEATH: Fallston
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2019 Laurel Brook Rd.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Elec. Exec.
12b. KIND OF BUSINESS OR INDUSTRY: Western Electric

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: fallston
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS / ZIP CODE: 2019 Laurel Brook Rd. 21047

14. FATHER'S NAME: Hance Parks
15. MOTHER'S MAIDEN NAME: Pearl Ford
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 215-10-4192
17. INFORMANT: Mrs. Edna Parks, Fallston, Md. ADDRESS 2019 Laurel Brook Rd. 21047

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Severe Peripheral Vascular Disease, Malnutrition, Dehydration

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/15 19 86 to 4/16 19 86 that (I) (we) last saw the deceased alive on 4/15 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Willard P. Amos DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 4/16/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Willard P. Amos
22e. ADDRESS: 2303 Belair Rd, Fallston, Md 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 4-19-1986
23c. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE: Baltimore Maryland

24. FUNERAL DIRECTOR NAME: Lassahn Funeral Home 1750 Belair Rd Kingsville, Md. 21087
25a. DATE REC'D. BY REGISTRAR: APR 23 1986
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy from Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic, the medical examiner must be notified and may

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-04840

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified (Code 4)

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11690

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harold	MIDDLE: Clarence	LAST: Parsons	2a. DATE OF DEATH MONTH: April	DAY: 22	YEAR: 1986
2b. HOUR: 4 p M					
3. SEX: Male	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 19, 1924	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: US Gov.t.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Harford	Aberdeen	YES [X] NO [ ]	58 Green St. 21001

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Clarence		Parsons	Blanche		Thomas

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	WW II	215-12-0473	Marylyn Parsons, Sames as Above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c): Cardiac Arrhythmias

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours 1 hour

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
	N/A	

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from April, 1986, to April 22, 1986, that (I) (we) last saw the deceased alive on April 22 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Manuel Mazzarella	MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	4/23/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MAZZARELLA, MANUEL	P.O. Box 519 Aberdeen, MD 21001

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	4/25/86	Bel Air Memorial	Bel Air, Harford, Maryland

24. FUNERAL DIRECTOR NAME, ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399	APR 25 1986	Barbara Davidson-Hendrickson

0-02858

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11691

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Claude — MIDDLE: A. — LAST: Perry

2a. DATE OF DEATH — MONTH DAY YEAR: April 3 1986

2b. HOUR: 855 P M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH — MONTH DAY YEAR: 8 13 1916

6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS
IF UNDER 24 HRS. — HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VA.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Mem Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FARMER

12b. KIND OF BUSINESS OR INDUSTRY: FARM

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: CECIL

13c. CITY OR TOWN: RISING SUN

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 12 WATSON WHEEL DR. 21911

14. FATHER'S NAME — FIRST: MILLARD — MIDDLE: — LAST: PERRY

15. MOTHER'S MAIDEN NAME — FIRST: SARA — MIDDLE: — LAST: SMITH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): — — — —

16b. SOCIAL SECURITY NO.: 223-24-1743

17. INFORMANT — ADDRESS: KATE G. PERRY (SAME AS 13A ABOVE)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic obstructive pulmonary disease
DUE TO, OR AS A CONSEQUENCE OF (c): Bronchopneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:
① Diabetes Mellitus ② Pneumothorax

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-5 19 86 to 4-3 19 86, that (I) (we) last saw the deceased alive on 4-3 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: SANG Sang W. Kim DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: April 3, 86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): SANG W. KIM

22e. ADDRESS: 308 S. Union Ave. Havre de Grace, MD 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 4-6-86

23c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cemetery

23d. LOCATION — CITY OR TOWN: Colora / COUNTY: Cecil / STATE: MD.

24. FUNERAL DIRECTOR — NAME: Richard L. Goodie Board Funeral Home / ADDRESS: Rising Sun Md

25a. DATE REC'D. BY REGISTRAR: APR 08 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

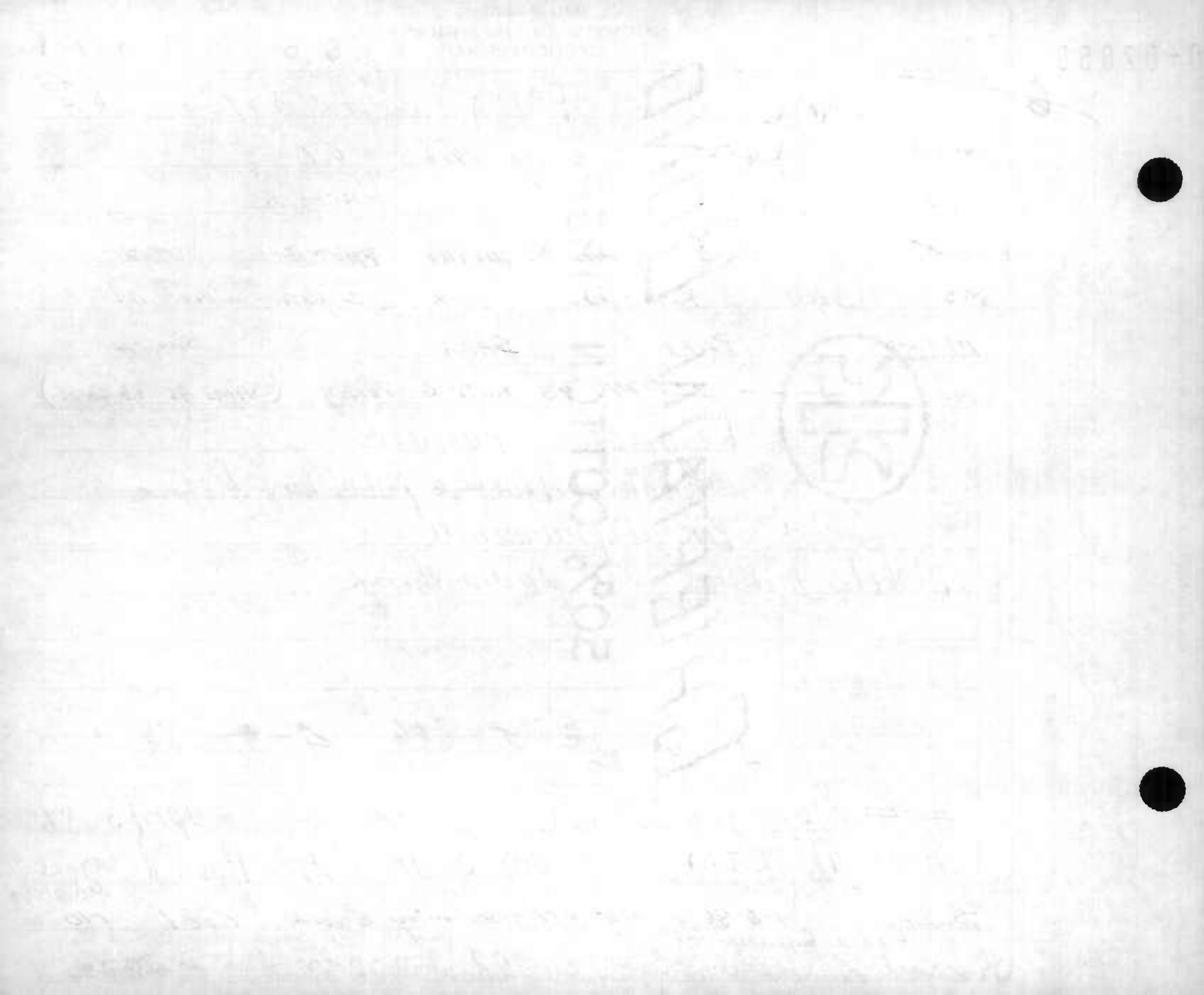
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)



0-02781

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11692
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: REGINA	MIDDLE: ELIZABETH	LAST: PERRY	2a. DATE OF DEATH MONTH DAY YEAR: APRIL 3, 1986	2b. HOUR: 9:30 PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 29, 1917	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Joppa, Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.		
10. CITY OR TOWN OF DEATH: Edgewood	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN ONE, GIVE STREET ADDRESS): 2611 Willoughby Beach Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner	12b. KIND OF BUSINESS OR INDUSTRY: Home Mobile/Park		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Edgewood	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: Edgewood,Md.21040 2611 Willoughby Beach Road

14. FATHER'S NAME FIRST / MIDDLE / LAST: John -- Cook		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Carrie -- Willick	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES): --	16b. SOCIAL SECURITY NO.: 216-56-6505	17. INFORMANT ADDRESS: Carl S.Perry,Jr., 2611 Willoughby Beach Rd Edgewood,Md. 21040

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b): Advanced lung cancer
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from Oct 7, 19 77, to Apr 3, 19 86, that (I) (we) last saw the deceased alive on ~~Feb~~ Mar 14 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 4-4-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): I.D. SOMERVILLE

22e. ADDRESS: 400 LEWIS ST HAVRE DE GRACE

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Apr.5,1986	23c. NAME OF CEMETERY OR CREMATORY: BelAir Memorial Gardens,	23d. LOCATION CITY OR TOWN: Bel Air	COUNTY: Harford STATE: Md.

24. FUNERAL DIRECTOR NAME / ADDRESS: Howard K. McComas III, Abingdon,Md. 21009	25a. DATE ACCEPTED BY REGISTRAR: APR 7 1986	25b. REGISTRAR'S SIGNATURE: [signature]	

0-03272

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11693 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ETHEL	MIDDLE: C.	LAST: PETZ	2a. DATE OF DEATH MONTH: 4	DAY: 4	YEAR: 86
2b. HOUR: 2:51 PM					
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: 2	DAY: 6	YEAR: 1900	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): BALTIMORE MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.		
10. CITY OR TOWN OF DEATH: BEL AIR MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bel Air Convalescent Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Baltimore	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 406 Regester Ave. 21212	
14. FATHER'S NAME FIRST: CHRISTIAN	MIDDLE: F.	LAST: LINDAUER	15. MOTHER'S MAIDEN NAME FIRST: CARRIE	MIDDLE:	LAST: BALD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): - - -	16b. SOCIAL SECURITY NO.: 215-07-8495	17. INFORMANT: H. Albert Petz, Jr.	ADDRESS: 1403 Perdue Ct. Bel Air, Md. 21014	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CEREBROVASCULAR ARTERIOSCLEROSIS — 4 YRS

DUE TO, OR AS A CONSEQUENCE OF (c): HYPERTENSION — 10 YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HYPEREMESIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 7/22 19 85 to 4/4 19 86, that (I) (we) last saw the deceased alive on 4/4 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert J. Rosenstiel MD — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 4/4/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT J. ROSENSTIEL MD — 22e. ADDRESS: 2602 CLARET DR. FALLSTON MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 4/8/86	23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.	23d. LOCATION (CITY OR TOWN / COUNTY / STATE): Baltimore, Md.
24. FUNERAL DIRECTOR NAME: MITCHELL-WIEDEFELD HOME, INC. ADDRESS: 6500 York Rd.	25a. DATE REC'D. BY REGISTRAR: APR 10 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked, then 18 should show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-03960

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11694 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, go then 18 show any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: GLADYS	MIDDLE: Amelia	LAST: PLEASANT	2a. DATE OF DEATH: MONTH 04	DAY 11	YEAR 86	2b. HOUR 6:50 A.M.
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH: MONTH 02	DAY 16	YEAR 11	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 2a HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.				
10. CITY OR TOWN OF DEATH: FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: HARFORD	13c. CITY OR TOWN: PYLESVILLE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 5312 ROCKS ROAD 21132			
14. FATHER'S NAME: FIRST Charles	MIDDLE Edward	LAST Hamilton	15. MOTHER'S MAIDEN NAME: FIRST Hattie	MIDDLE Etta	LAST Govans		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-20-7681	17. INFORMANT: Robert Pleasant Jr.	ADDRESS: same as above			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Ischemic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4/1 19 86, to 4/10 19 86, that (I) (we) last saw the deceased alive on 4/9 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joseph Reinhardt — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 4/11/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT) — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 4/15/1986	23c. NAME OF CEMETERY OR CREMATORY: Jarrettsville Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Jarrettsville, Harford, Md.	
24. FUNERAL DIRECTOR NAME: M. Gladden Kurtz	ADDRESS: Jarrettsville, Md.	25a. DATE REC'D. BY REGISTRAR: APR 16 1986	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rogers	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

0-04339

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11695

1. DECEASED NAME (TYPE OR PRINT) — FIRST: NorMAN — MIDDLE: JOE — LAST: Powers

2a. DATE OF DEATH — MONTH: April — DAY: 16 — YEAR: 1986

2b. HOUR: 12:55 PM

3. SEX: Male

4. RACE: white

5. DATE OF BIRTH — MONTH DAY YEAR: January 31, 1935

6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NorthCarolina

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Painter

12b. KIND OF BUSINESS OR INDUSTRY: Self-employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Cecil — 13c. CITY OR TOWN: Port Deposit

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 20 Rutledge Lane Box 114 — 21904

14. FATHER'S NAME — FIRST: Saul — MIDDLE: — LAST: Powers

15. MOTHER'S MAIDEN NAME — FIRST: Clyde — MIDDLE: — LAST: Hart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): -------

16b. SOCIAL SECURITY NO.: 216-30-9086

17. INFORMANT — ADDRESS: Barbara L. Powers, P.O. Box 114 Port Deposit, Md 21904

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIOGENIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF (b): EXTENSIVE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (c): ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 4-16, 1986, to 4-16, 1986, that (I) (we) last saw the deceased alive on 4-16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 4/16/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dante U. Monakic, MD

22e. ADDRESS: Harve de Grace, Md 21078

NAME

ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: April 19, 1986

23c. NAME OF CEMETERY OR CREMATORY: Harmony Chapel Cem.

23d. LOCATION — CITY OR TOWN: Liberty Grove — COUNTY: Cecil — STATE: Md.

24a. FUNERAL DIRECTOR: Lee A. Patterson & Son

ADDRESS: Lee A. Patterson & Son, Perryville, Md. 21903

25a. DATE REC'D BY REGISTRAR: APR 22 1986

25b. REGISTRAR'S SIGNATURE

00-03116

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 86

REG. NO. 11696

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18 PART I. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Scott	MIDDLE: Thomas	LAST: Ramsey	2a. DATE KNOWN OF DEATH ESTIMATED ☑	MONTH: 4	DAY: 6	YEAR: 19 86	2b. HOUR: 3 P M
3. SEX: M	4. RACE: W	5. DATE OF BIRTH MONTH: 3	DAY: 7	YEAR: 66	6. AGE (IN YEARS LAST BIRTHDAY): 20 YRS.	IF UNDER 1 YR. MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN:	2c. DATE PRONOUNCED DEAD MONTH: 4	DAY: 6	YEAR: 19 86	2d. HOUR: 6 10 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.										
10. CITY OR TOWN OF DEATH: Jarrettsville	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3605 Anderson La	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student	12b. KIND OF BUSINESS OR INDUSTRY: College										
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Pa.	13b. COUNTY: York	13c. CITY OR TOWN: Delta	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 1012 Court Hey Ln 17314 Capture Hill									
14. FATHER'S NAME FIRST: William	MIDDLE: L.	LAST: Ramsey	15. MOTHER'S MAIDEN NAME FIRST: Janet	MIDDLE:	LAST: Winebarger								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 216-02-4406	17. INFORMANT: William L. Ramsey	ADDRESS: 3605 Anderson La 21084									

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Self inflicted wound to head	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Depression	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Luis E Ronyel M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 4-6-86

EXAMINER'S NAME (TYPE OR PRINT): Luis E Ronyel ADDRESS: 464 Alliance Vt

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	4/10/86	Jarrettsville Cem.	Jarrettsville Harford Md.

24. FUNERAL DIRECTOR NAME: Benjamin W. Kurtz ADDRESS: Jarrettsville, Md.

25a. DATE REC'D. BY REGISTRAR: APR 9 1986 25b. REGISTRAR'S SIGNATURE: Julia Faith Rader

DHMH - 17
(VR A15 ME (5))

0-05034

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11697

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Hayward — MIDDLE: Charles — LAST: Richardson

2a. DATE OF DEATH — MONTH: 4 — DAY: 18 — YEAR: 86

2b. HOUR: 8p M

3. SEX: male

4. RACE: white

5. DATE OF BIRTH — MONTH: 12 — DAY: 14 — YEAR: 49

6. AGE (IN YEARS LAST BIRTHDAY): 36 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD U.S.A.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Pylesville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1506 Harkins Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Postal worker

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: Harford — 13c. CITY OR TOWN: Pylesville — 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ — 13e. STREET ADDRESS / ZIP CODE: 1506 Harkins Road Pylesville Md 21132

14. FATHER'S NAME — FIRST: Hayward — MIDDLE: Charles — LAST: Richardson

15. MOTHER'S MAIDEN NAME — FIRST: Helen — MIDDLE: Jane — LAST: Whiteford

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): —

16b. SOCIAL SECURITY NO.: 212-52-5784

17. INFORMANT — ADDRESS: Physician - Bf. Polk - see below

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SEPSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Immunodeficiency — 2 years

DUE TO, OR AS A CONSEQUENCE OF (c): Recurrent infection — 4 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) this hospital) attended the deceased from June 11, 19 85, to April 18, 19 86, that (I) we) last saw the deceased alive on March 1, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: B Frank Polk — DEGREE: MD — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 4/21/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): B FRANK POLK

22e. ADDRESS: 615 N. Wolfe St., Baltimore MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 4-21-86

23c. NAME OF CEMETERY OR CREMATORY: FAWN GROVE CEM.

23d. LOCATION — CITY OR TOWN: FAWN GROVE — COUNTY: YORK — STATE: PA

24. FUNERAL DIRECTOR — NAME: JOHN HARKINS — ADDRESS: 600 MAIN ST. DELTA, PA

25a. DATE REC'D. BY REGISTRAR: APR 28 1986 — REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body from the state.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83 (VRA 15, 4)

00-02447

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11698
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or there is shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
WAYNE	EDWARD	SALISBURY	April 1, 1986	8:40 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	June 3, 1940	45 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARITAL STATUS	9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, Md.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Harford County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Fallston	Fallston General Hospital	Tool & Die Maker	Ceramics

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Bel Air	YES [ ] NO [X]	504 Westview Road 21014

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Henry	Bernard	Salisbury	Edith	E.	Watchman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	--	218-40-9928	Mrs. Carol E. Salisbury	Bel Air, Md. 21014, 504 Westview Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Acute coronary insufficiency

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital attended the deceased from Jan. 5 '76 to April 1 19 86, that (I) (we) last saw the deceased alive on 2/Ba 19 ____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
[signature]	M.D.	[X]	4/2/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
H. AKAKAWA M.D.	319 So. Union Ave. Havre de Grace Md. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Apr. 3, 1986	R.A. Ferris Crematory	W. Chester Chester Pa.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009	APR 03 1986	Julia Davidson-Randall

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

10-02942

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11699

1. DECEASED NAME (TYPE OR PRINT): FIRST MADELINE MIDDLE V. LAST SEIDOMRIDGE

2a. DATE OF DEATH: MONTH April DAY 4, YEAR '86

2b. HOUR 11:15 AM

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH: MONTH DEC. DAY 24 YEAR 1904

6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford Co. MD.

10. CITY OR TOWN OF DEATH: Fallston

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER

12b. KIND OF BUSINESS OR INDUSTRY: -

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: ~~BALTIMORE~~

13c. CITY OR TOWN: KINGSVILLE

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 900 MONICA CIRCLE 21087

14. FATHER'S NAME: FIRST ~~CHARLES~~ LAST PAGE

15. MOTHER'S MAIDEN NAME: FIRST ALICE MIDDLE LAST BOYD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214-18-5596

17. INFORMANT: JUNE MYERS (DGHTR) SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11:15 Am

DUE TO, OR AS A CONSEQUENCE OF (b): Probable Acute Myocardiac Infarction and/or CVA (Stroke) x yrs

DUE TO, OR AS A CONSEQUENCE OF (c): Severe asthma, ischemic heart disease, Angina

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Respiratory failure, Carcinoma of Colon at Cecum

19a. DATE OF OPERATION: April 1st '86

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of Colon at Cecum

19c. AUTOPSY? YES ☐ NO ☒

20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR N/A

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): N/A

21d. INJURY OCCURRED: HOME ☐ AT WORK ☐ NOT WHILE AT WORK ☐ N/A

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital) attended the deceased from Mar. 13, 86 to April 4, 19 86 that (I) we) last saw the deceased alive on April 4 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I, we) did (did not) view the body after death.

22b. SIGNATURE: Albert S.C. Sun, M.D.

DEGREE: (Medical) Surgeon: Dr. Qureshi

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 4/4/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Albert S.C. Sun, M.D.

22e. ADDRESS: 1800 Harford Rd. Fallston, MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 4/7/86

23c. NAME OF CEMETERY OR CREMATORY: BALTO. NAT'L

23d. LOCATION: CITY OR TOWN BALTIMORE COUNTY STATE MD.

24. FUNERAL DIRECTOR: NAME SCHIMUNEK FUNERAL HOME, INC. ADDRESS 9705 Belair Rd., Balto. Md. 21236

25a. DATE REC'D BY REGISTRAR: APR 8 1986

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

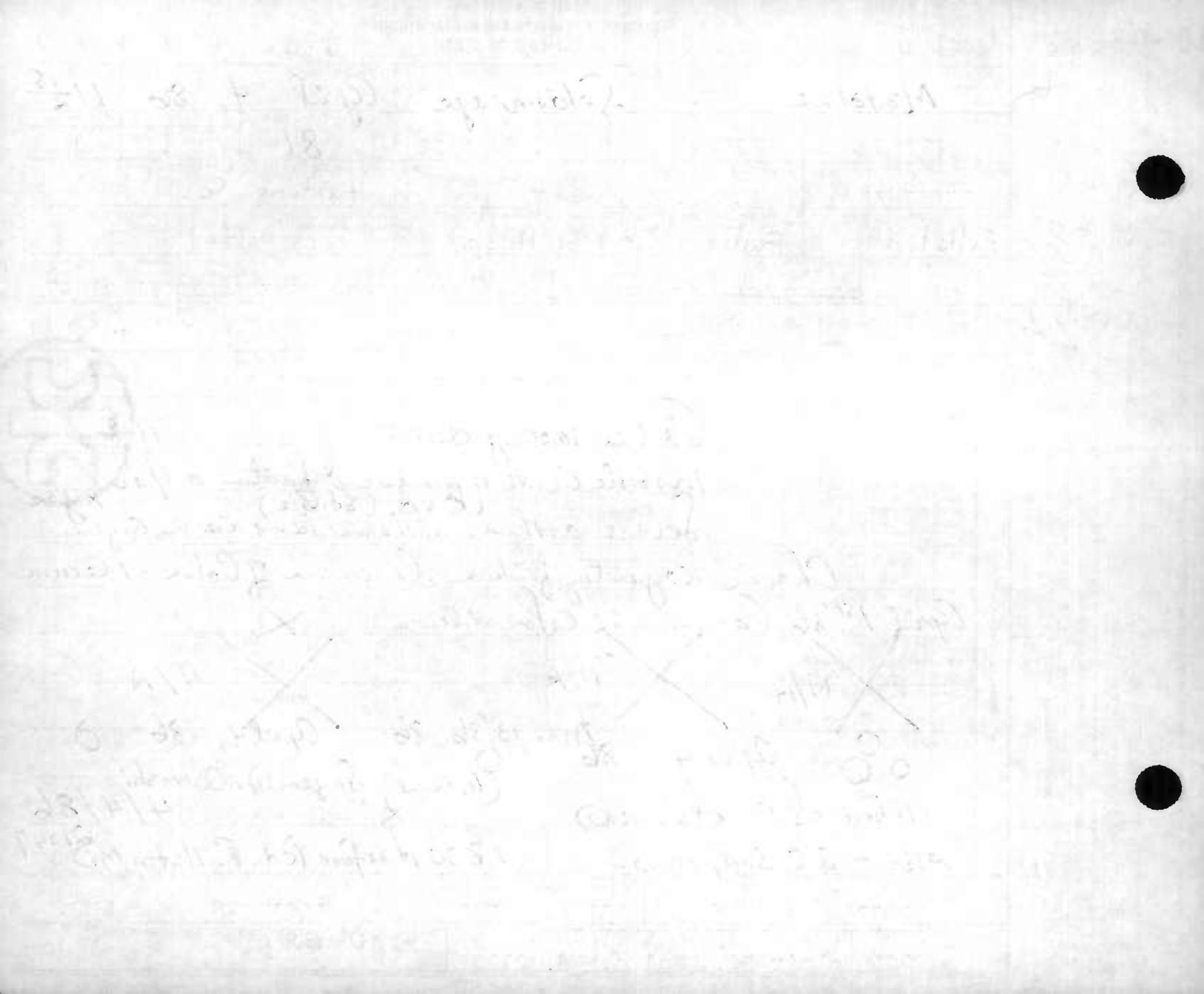
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)



00-02809

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

86 11700 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Alice — MIDDLE: M. — LAST: Sinclair

2a. DATE OF DEATH — MONTH DAY YEAR: April 4, 1986

2b. HOUR: 1:05 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: March 29 1907

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laundry Service

12b. KIND OF BUSINESS OR INDUSTRY: V.A.M.C.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Cecil

13c. CITY OR TOWN: Perryville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 625 Richmond Street 21903

14. FATHER'S NAME — FIRST: Andrew — MIDDLE: J. — LAST: Bird

15. MOTHER'S MAIDEN NAME — FIRST: Melinda — MIDDLE: ---- — LAST: Barrow

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ------

16b. SOCIAL SECURITY NO.: 217-05-4145

17. INFORMANT — ADDRESS: James W. Thompson, Jr., 421 Broad Street, Perryville, Md. 21903

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial infarction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes mellitus

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 19 75 to April 4 19 86 that (I) (we) last saw the deceased alive on April 4 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John D Yun DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. LICENSE NO.: H5186

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN D YUN

22e. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: April 7,1986

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION — CITY OR TOWN: Port Deposit — COUNTY: Cecil — STATE: Maryland

24. FUNERAL DIRECTOR — NAME: Lee A. Patterson & Son — ADDRESS: Perryville, Maryland

25a. DATE REC'D. BY REGISTRAR: APR 07 1986

25b. REGISTRAR'S SIGNATURE

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

00-04106

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11701

1. DECEASED NAME (TYPE OR PRINT) FIRST: VERNON	MIDDLE: F.	LAST: Smith	2a. DATE OF DEATH MONTH DAY YEAR: April 13, 1986	2b. HOUR: 1P M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: August 15 1907	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penna	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck driver	12b. KIND OF BUSINESS OR INDUSTRY: Transportation		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Fallston	YES ☐ NO XX	2921 Guyton Rd., 21047

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Curtis E. Smith	Sadie Diffendarfer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	----	216-10-8894	Elmer V. Smith, 2921 Guyton Rd., Fallston, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): STROKE
DUE TO, OR AS A CONSEQUENCE OF (c): HYPERTENSIVE ARTERIOSCLEROTIC DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO XX	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-20, 19 86, to 4-13, 19 86, that (I) (we) last saw the deceased alive on 4-13, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Dante M. Monakil	ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	4/13/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DANTE M. MONAKIL	HAVRE de GRACE, Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial Southern	April 16, 1986	Dublin Southern	Dublin Harford Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John H. Harkins 600 Main St., Delta, Pa., 17314	APR 18 1986	Irma Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-04210

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11702 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardboard papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) First: HENRY	Middle: ALEXANDER	Last: SONBERG	2a. DATE OF DEATH Month Day Year: April 17, 1986	2b. HOUR: 10:03 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: April 28, 1918	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Abingdon, Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.	
10. CITY OR TOWN OF DEATH: Abingdon	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1314 Abingdon Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Postmaster	12b. KIND OF BUSINESS OR INDUSTRY: US Postal Service

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Abingdon	YES ☐ NO ☒	1314 Abingdon Road 21009

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	James	Sonberg	Anna	---	Pouska

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	--	212-12-5969	Lillian Sonberg, 1314 Abingdon Road, Abingdon	Md. 21009

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) EMPHYSEMA, BRONCHIECTSIS WITH

DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) ADENOCARCINOMA OF LUNG WITH METASTASES BRAIN

Approximate interval between onset and death:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY Hour A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION Street / City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from JAN 9, 1960 to APR 17, 19 1986, that (I) (last saw the deceased alive on APRIL 17 19 86, and that in (my) (opinion) death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Philip W. Heuman M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	4-18-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Philip W. Heuman, M.D.	307 Hickory Ave., Bel Air, Md. 21014

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION City or Town / County / State
Burial	April 21, 1986	Cokesbury U.M.Cemetery,	Abingdon Harford Md.

24. FUNERAL DIRECTOR Name / Address	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009	APR 21 1986	Julia Davidson-Hardesty

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-05023

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11703

1. DECEASED NAME (TYPE OR PRINT) — FIRST: DELLA — MIDDLE: EMALINE — LAST: SPARKS

2a. DATE OF DEATH — MONTH: 4 — DAY: 21 — YEAR: 86

2b. HOUR: 7:15 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH: 7 — DAY: 12 — YEAR: 98

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia — Lovelia

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Fallston (21047)

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Homemaker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford Co.

13c. CITY OR TOWN: Bel Air (21014)

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 224 Eastern Avenue 21014

14. FATHER'S NAME — FIRST: Silas — MIDDLE: — LAST: Morrison

15. MOTHER'S MAIDEN NAME — FIRST: Minerva — MIDDLE: — LAST: Crookshank

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): —

16b. SOCIAL SECURITY NO.: 215-12-8766 F2

17. INFORMANT (SON) 838-3351: Mr. Kenneth F. Sparks — ADDRESS: 106 Woodland Drive Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Card arrest

DUE TO, OR AS A CONSEQUENCE OF (b): End Stage COPD

DUE TO, OR AS A CONSEQUENCE OF (c): CHF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD, Coronary Arteriosclerosis.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ — NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/15 19 86 to 4/21 19 86 that (I) (we) last saw the deceased alive on 4/21 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 4-21-86

22d. PHYSICIAN'S NAME (TYPED OR PRINTED): V. S. Nair M.D.

22e. ADDRESS: 2112 Bel Air Road, Fallston, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: April 24, 1986

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION — CITY OR TOWN: Bel Air — COUNTY: Harford Co. — STATE: Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: 50 W. Broadway & Williams St. Bel Air, Maryland 21014

25a. DATE REC'D. BY REGISTRAR: APR 28 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Bender

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

00-03339

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11704

1. DECEASED NAME (TYPE OR PRINT): FIRST Winifred MIDDLE Augusta LAST Spies
   (Winifred / Spies)

2a. DATE OF DEATH: MONTH 4 DAY 9 YEAR 86
2b. HOUR 12 45 P M

3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 2 DAY 24 YEAR 14
6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.
   IF UNDER 1 YEAR: MONTHS / DAYS
   IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Connecticut
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Fallston
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: --

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Abingdon
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 3901 Philadelphia Road 21009

14. FATHER'S NAME: FIRST Thomas MIDDLE Carter LAST Morgan
15. MOTHER'S MAIDEN NAME: FIRST Augusta MIDDLE Florence LAST Rosier

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES): --
16b. SOCIAL SECURITY NO.: 213-05-8155
17. INFORMANT: Frederick J. Spies, 3901 Philadelphia Road ADDRESS: Abingdon, Md. 21009

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute MI — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO, OR AS A CONSEQUENCE OF (b): CHF — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 4/9, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature]
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 4/9/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): VRA SP
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: April 12, 1986
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION: CITY OR TOWN: Bel Air / COUNTY: Harford / STATE: Md.

24. FUNERAL DIRECTOR NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009
25a. DATE RECEIVED BY REGISTRAR: APR 11 1986
25b. REGISTRAR'S SIGNATURE: [signature]

00-04338

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REG. NO. 11705

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
G	Bart	Stone	April	20	1986 / 3:49 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	Nov.	17,	1920	65 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.A.		Harford MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Havre de Grace	Harford Memorial Hospital	Psychologist	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Havre deGrace	YES X NO	2 Chesapeake Drive 21078

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Gideon	Barto	Stone	Bess		Keller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (SPECIFY NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW II	186-16-6595	Nancy J. Stone, 2 Chesapeake Dr., Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES / NO X	YES / NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 84 to 4-20 19 86, that (I) (we) last saw the deceased alive on 4-20 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN X / MEDICAL DIRECTOR / STAFF PHYSICIAN	4-20-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GUNTHER HIRSCH	131. S. UNION AV. HAVRE DE GRACE Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	April 23, 1986	R.A. Ferris & Co	West Chester, West Goshen, Pa.

24. FUNERAL DIRECTOR (SIGNATURE) ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee R. Patterson & Son, Perryville, Maryland.	APR 22 1986	

00-0299

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified case.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11706

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Olive — MIDDLE: Cathleen — LAST: Thomas
2a. DATE OF DEATH — MONTH: 4 — DAY: 7 — YEAR: 86
2b. HOUR: 5 AM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH — MONTH: 4 — DAY: 28 — YEAR: 00
6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.
10. CITY OR TOWN OF DEATH: Fallston
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired
12b. KIND OF BUSINESS OR INDUSTRY: Homemaker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Harford
13c. CITY OR TOWN: Havre de Grace
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET ADDRESS / ZIP CODE: 4413 Webster Lapidum Rd. 21078

14. FATHER'S NAME — FIRST: Alonzo — MIDDLE: — LAST: Beaver
15. MOTHER'S MAIDEN NAME — FIRST: Minerva — MIDDLE: J. — LAST: Swiger
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
16b. (IF YES, GIVE WAR OR DATES): N/A
16b. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: R.L.Thomas, 4413 Webster-Lapidum Rd., H de G., MD 21078

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LUNG CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): DIABETES — Years
DUE TO, OR AS A CONSEQUENCE OF (c): CHRONIC DEBILITATION — 2 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/15, 19 86, to 4/7, 19 86, that (I) (we) last saw the deceased alive on 4/5, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 4/7/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): R. PHILLIPS
22e. ADDRESS: 2005 Rock Spring Rd. Forest Hill

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Apr. 10, 1986
23c. NAME OF CEMETERY OR CREMATORY: Moreland Memorial
23d. LOCATION — CITY OR TOWN: Baltimore, — COUNTY: Maryland — STATE
24. FUNERAL DIRECTOR — NAME — ADDRESS: Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399
25a. DATE REC'D. BY REGISTRAR: APR 09 1986
25b. REGISTRAR'S SIGNATURE: Gina Davidson-Hendrix

00-05481

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11707

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Nellie	Hess	Tipton	April 26, 1986	1:00A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	Caucasian	Feb. 4, 1893	93 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Harford MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Jarrettsville	3754 Federal Hill Road	Housewife	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Jarrettsville	YES [ ] NO [X]	3754 Federal Hill Road 21084

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles		Hess	Rachel	Evans	Ball

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		218-76-1088	John M. Tipton Sr.	Jarrettsville

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Recurrent Breast Cancer. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 yr.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Senile Dementia, Parkinson's Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [X]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/24 19 86, to 4/25 19 86, that (I) (we) last saw the deceased alive on 4/21 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	4/26/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Randall C. Cronin, Jr., M.D.	721 Wheeler School Rd. Whiteford, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	4/28/1986	Jarrettsville Cem.	Jarrettsville	Harford	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR
M. Gladden Kurtz	Jarrettsville, Md.	MAY 01 1986 [signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11708

1. DECEASED NAME (TYPE OR PRINT): JOHN S. TYLEE
2a. DATE OF DEATH: 4 21 86
2b. HOUR: 5:20 A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 4 1 28
6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY? U.S.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.
10. CITY OR TOWN OF DEATH: Joppa
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 33 Neptune Dr.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer
12b. KIND OF BUSINESS OR INDUSTRY: Construction

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Harford
13c. CITY OR TOWN: Joppa
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET ADDRESS: 33 Neptune Drive 21234

14. FATHER'S NAME: Don O. Tylee
15. MOTHER'S MAIDEN NAME: Martha Falkenstein
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 188-20-3359
17. INFORMANT ADDRESS: Mrs. Jeanne Tylee Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b): Esophageal cancer
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from August 9, 19 85, to April 20, 19 86, that (I) (we) last saw the deceased alive on April 8, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Fleta H Sokal
DEGREE: MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 4/22/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Fleta H Sokal MD
22e. ADDRESS: 626 Towne Center Dr Suite 202

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal
23b. DATE: 4-21-86
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME: Anatomy Board ADDRESS: Balto., Md.
25a. DATE REC'D. BY REGISTRAR: APR 29 1986
25b. REGISTRAR'S SIGNATURE: Julia Davidson Rhodes

DIVISION OF VITAL RECORDS, 201 PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual circumstances, a report must be made to the Medical Examiner.

DHMH - 16 50M 1/81 (VRA 15, 4)

RECEIVED APR 24 1986 BALTIMORE, MARYLAND

ANATOMY BOARD OF MARYLAND BALTIMORE, MARYLAND

RECEIVED APR 29 1986 BALTIMORE, MARYLAND

0-02859

Film G615 item 16b
5/28/86 rja

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11709

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Joseph A. Vachek
2a. DATE OF DEATH MONTH DAY YEAR	April 5 1986
2b. HOUR	9:50 A.M.
3. SEX	Male
4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	Oct. 26, 1904
6. AGE (IN YEARS LAST BIRTHDAY)	81 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	
IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Czechoslovakia
7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Harford MD.
10. CITY OR TOWN OF DEATH	Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Harford Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Mgr. Machine Shop
12b. KIND OF BUSINESS OR INDUSTRY	Shoe
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland
13b. COUNTY	Harford
13c. CITY OR TOWN	Abingdon
13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET ADDRESS / ZIP CODE	905 Philadelphia Avenue 21009
14. FATHER'S NAME FIRST / MIDDLE / LAST	Alois -- Vachek
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Julia -- Stastny
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No
(IF YES, GIVE WAR OR DATES)	--
16b. SOCIAL SECURITY NO.	215-38-3140
17. INFORMANT ADDRESS	Mrs. Beatrice Vachek, 905 Philadelphia Ave Abingdon, Md. 21009

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	uremia	2 months
DUE TO, OR AS A CONSEQUENCE OF (b)	nephrosclerosis	> 5 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Alzheimer's disease, arteriosclerotic heart disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~his hospital~~) attended the deceased from March 31, 19__, to April 5, 19 86, that (I) (~~we~~) last saw the deceased alive on April 5, 19 86, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN [X] / MEDICAL DIRECTOR [ ] / STAFF PHYSICIAN [ ]	22c. DATE SIGNED
B J Abrutat Jr	MD		April 6, 1986
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Cremation	April 6, 1986	R.A. Ferris Crematory	W. Chester	Chester Pa.
24. FUNERAL DIRECTOR NAME / ADDRESS	Howard K. McComas III, Abingdon, Md. 21009	25a. DATE REC'D. BY REGISTRAR	APR 08 1986	25b. REGISTRAR'S SIGNATURE

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-05181

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 | 11710
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or items 18 show any injury, or other traumatic event, the medical examiner must be notified or may be required to assume jurisdiction.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Catherine MIDDLE: Mae LAST: Welsh				2a. DATE OF DEATH MONTH DAY YEAR: April 28, 1986	2b. HOUR: 9:54 A.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 24, 1910	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Mem. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: --	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Aberdeen	YES [ ] NO [X]	2030 W. Park Beach Drive, Aberdeen, Md. 21001

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Harry -- Sheridan	Hattie -- Mahan	no --	212-34-6577	Charles T. Welsh, 2030 W. Park Beach Drive, Aberdeen, Md. 21001

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 YR
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: peripheral vascular disease, arteriosclerotic heart disease, rheumatoid arthritis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4-21 19 86, to 4-28 19 86, that (I) (we) last saw the deceased alive on 4-28 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
B J Plunkett Jr MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	4-29-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	April 30, 1986	St. George's Episcopal Cem.	Perryman, Harford, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009	APR 30 1986	

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

C#: 04442

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

8 6 | 1 1 7 1 1 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Charlotte	MIDDLE: C.	LAST: Wisel	2a. DATE OF DEATH MONTH: 4	DAY: 15	YEAR: 86	2b. HOUR: 4:30P.M
3. SEX: Female	4. RACE: CAUCASIAN (XXXXXXXXX)	5. DATE OF BIRTH MONTH: 3	DAY: 25	YEAR: 1898	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): GERMANY	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford COUNTY MD.				
10. CITY OR TOWN OF DEATH: Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: AT HOME				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Harford	13c. CITY OR TOWN: Fallston	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET ADDRESS / ZIP CODE: 502 BEECHCROFT RD. 21047			
14. FATHER'S NAME FIRST: UNKNOWN	MIDDLE	LAST: COHN	15. MOTHER'S MAIDEN NAME FIRST: UNKNOWN	MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 215-38-1762	17. INFORMANT ADDRESS: WILLIAM W. WISEL 502 BEECHCROFT RD. FALLSTON, 21047 MD				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): SEPSIS
DUE TO, OR AS A CONSEQUENCE OF (b): PNEUMONITIS, combined GRAM (+) and (-)
DUE TO, OR AS A CONSEQUENCE OF (c): _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Diabetes Mellitus, CVA's, Chronic renal insufficiency

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY Ooccurred (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): —
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: —

22a. I certify that (I) (~~the hospital~~) attended the deceased from 1/26/82, 19____, to 04/15/86, 19____, that (I) (~~saw~~) last saw the deceased alive on 04/14/86, 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 04/15/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DAVID R. PADRINO	22e. ADDRESS: 1212 Churchville Rd. Bel Air, 21014		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 4/18/86	23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON CEM	23d. LOCATION: BALTIMORE	MARYLAND STATE
24. FUNERAL DIRECTOR NAME / ADDRESS: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215		25a. DATE REC'D. BY REGISTRAR: APR 23 1986	25b. REGISTRAR'S SIGNATURE: [signature]	

0-03222

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11712

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ROBY	K.	WOOD	April 6, 1986	11:14 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
MALE	WHITE	OCTOBER 28, 1899	86 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
NORTH CAROLINA	USA		Harford MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Havre de Grace	Harford Memorial Hospital	(RET) FARMER	AGRICULTURE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	HARFORD	ABERDEEN	YES ☒ NO ☐	602 WALKER STREET 21001

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
?		WOOD	?		?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		219 07 1975	MR. RAYMOND WOOD 440 FRANKLIN ST. BEL AIR, MD. 21014

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Renal Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Severe Dehydration; Severe Hypothermia, Pneumonia (2)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) (this hospital) attended the deceased from 4/2/86, 19 86, to 4/6, 19 86, that (I) (we) last saw the deceased alive on 4/6, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
R. de Lo Santos	MD		

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
R. de Lo Santos	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	10 Apr. 86	Bel Air Mem. Gardens	Bel Air, Harford Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078	APR 10 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-3410

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 11713

1. DECEASED NAME (TYPE OR PRINT): FIRST Marion MIDDLE Ellen LAST Young
Marion Young

2a. DATE OF DEATH: MONTH 4 DAY 11 YEAR 86
2b. HOUR 8:30 P M

3. SEX: F
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH June DAY 29 YEAR 1912
6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pleasant Gap, Pa.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Bel Air
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Belair Convalescent Center
12a. USUAL OCCUPATION (TYPE OF WORK DONE FOR MOST OF WORKING LIFE): Waitress
12b. KIND OF BUSINESS OR INDUSTRY: Restaurant

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Forest Hill
13d. INSIDE CITY LIMITS? YES ☐ NO ☒ xx
13e. STREET ADDRESS / ZIP CODE: 109 Marshall Drive, Forest Hill, Md 21050

14. FATHER'S NAME: FIRST William MIDDLE Henry LAST Knoffsinger
15. MOTHER'S MAIDEN NAME: FIRST Cora MIDDLE Ellen LAST Myers

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES): --
16b. SOCIAL SECURITY NO.: 195-16-5556
17. INFORMANT: Mrs. Shirley E. Neff
ADDRESS: 109 Marshall Drive, Forest Hill, Md. 21050

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of Colon with Widespread Lymph Node Metastases
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic Heart Disease; Liver Failure Anemia

19a. DATE OF OPERATION: 1/28/86
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Advanced Cancer of Colon
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 19 85 to 4/10 19 86 that (I) (we) last saw the deceased alive on 4/10 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Willard P. Amoss DEGREE
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 4/12/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Willard P. Amoss
22e. ADDRESS: 2303 Belair Rd, Fallston, Md 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: April 15, 1986
23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
23d. LOCATION: CITY OR TOWN Bellefonte COUNTY Centre STATE Pa.

24. FUNERAL DIRECTOR: NAME AND ADDRESS: Howard K. McComas III, Abingdon, Md. 21009
25a. DATE REC'D. BY REGISTRAR: APR 14 1986
25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)